MMWR™

Morbidity and Mortality Weekly Report

Weekly September 8, 2006 / Vol. 55 / No. 35

Evaluation of a Fruit and Vegetable Distribution Program — Mississippi, 2004–05 School Year

Although diets high in fruit and vegetables are associated with decreased risk for many chronic diseases (*1*), consumption of fruit and vegetables among children is below recommended levels (*2*). During the 2004–05 school year, the Mississippi Department of Education Child Nutrition Program initiated the Mississippi Fresh Fruit and Vegetable Pilot Program. The program was designed to 1) increase student access to fresh fruit and vegetables, 2) increase the degree of student preference for fruit and vegetables, and 3) increase fruit and vegetable consumption. The 25 schools selected to participate in the program distributed fresh fruit and vegetables free of charge during the school day and provided nutrition education activities to promote and support consumption of fruit and vegetables. An evaluation of the program was conducted using a pretest in the fall (before the program was implemented by the schools) and a posttest in the spring (at the end of the school year). This report summarizes the findings of that evaluation, which indicated that the program might have 1) increased the variety of fruit and vegetables ever tried by students from all three grades sampled (5th, 8th, and 10th); 2) increased the degree of preference for fruit among 8th-grade and 10th-grade students; 3) promoted positive attitudes toward eating fruit among 8th-grade students; 4) increased consumption of fruit, but not vegetables, among 8th-grade and 10th-grade students; and 5) decreased preference for fruit and vegetables, the belief that they could eat more vegetables, and willingness to try new fruit and vegetables among 5th-grade students. The results of this evaluation suggest that the distribution of fresh fruit at school free of charge to secondary school students might be an effective component of a comprehensive approach for improving student dietary behaviors; however, distribution of fresh vegetables might be more effective with changes in program implementation.

Evaluation of the pilot program featured a one-group (no comparison) pretest-posttest design involving students in grades 5, 8, and 10 from five of the 25 schools* participating in the pilot program. The five evaluation schools were selected on the basis of grade levels served, geographic area, urbanicity, and racial composition but were not intended to be representative of students in the pilot program or of students in the entire state.

The evaluation of the pilot program consisted of a survey and a 24-hour dietary recall interview. The survey assessed changes in the following during the school year: 1) the variety of fruit and vegetables ever eaten by students, 2) their attitudes toward fruit and vegetables, 3) their willingness to try fruit and vegetables, 4) their degree of preference for and familiarity with fruit and vegetables, and 5) their intentions to eat fruit and vegetables. The survey was administered by trained data collectors during the school day to 725 students in grades 5, 8, and 10 in the five selected schools. The 24-hour dietary recall interview was conducted to assess changes in student consumption of fruit and vegetables during the school year. Dietitians and trained nutrition interviewers interviewed a random sample of 207 students in grades 8 and 10 representing three of the five selected schools.† They

* The 25 schools were selected competitively by the Mississippi Department of Education from among those that applied for funds for the Fresh Fruit and Vegetable Pilot Program.

† Because young children might not be able to provide reliable data on dietary recall interviews, only 8th-grade and 10th-grade students were administered these interviews.

INSIDE

961 Update: Delayed Onset *Pseudomonas fluorescens* Bloodstream Infections After Exposure to Contaminated Heparin Flush — Michigan and South Dakota, 2005–2006
963 Measles Outbreak and Response — Fiji, February–May 2006
966 Notices to Readers
968 QuickStats

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR DISEASE CONTROL AND PREVENTION

The *MMWR* series of publications is published by the Coordinating Center for Health Information and Service, Centers for Disease Control and Prevention (CDC), U.S. Department of Health and Human Services, Atlanta, GA 30333.

Suggested Citation: Centers for Disease Control and Prevention. [Article title]. MMWR 2006;55:[inclusive page numbers].

Centers for Disease Control and Prevention

Julie L. Gerberding, MD, MPH
Director

Tanja Popovic, MD, PhD
(Acting) Chief Science Officer

James W. Stephens, PhD
(Acting) Associate Director for Science

Steven L. Solomon, MD
Director, Coordinating Center for Health Information and Service

Jay M. Bernhardt, PhD, MPH
Director, National Center for Health Marketing

Judith R. Aguilar
(Acting) Director, Division of Health Information Dissemination (Proposed)

Editorial and Production Staff

Eric E. Mast, MD, MPH
(Acting) Editor, MMWR Series

Suzanne M. Hewitt, MPA
Managing Editor, MMWR Series

Douglas W. Weatherwax
(Acting) Lead Technical Writer-Editor

Catherine H. Bricker, MS
Jude C. Rutledge
Writers-Editors

Beverly J. Holland
Lead Visual Information Specialist

Lynda G. Cupell
Malbea A. LaPete
Visual Information Specialists

Quang M. Doan, MBA
Erica R. Shaver
Information Technology Specialists

Editorial Board

William L. Roper, MD, MPH, Chapel Hill, NC, Chairman
Virginia A. Caine, MD, Indianapolis, IN
David W. Fleming, MD, Seattle, WA
William E. Halperin, MD, DrPH, MPH, Newark, NJ
Margaret A. Hamburg, MD, Washington, DC
King K. Holmes, MD, PhD, Seattle, WA
Deborah Holtzman, PhD, Atlanta, GA
John K. Iglehart, Bethesda, MD
Dennis G. Maki, MD, Madison, WI
Sue Mallonee, MPH, Oklahoma City, OK
Stanley A. Plotkin, MD, Doylestown, PA
Patricia Quinlisk, MD, MPH, Des Moines, IA
Patrick L. Remington, MD, MPH, Madison, WI
Barbara K. Rimer, DrPH, Chapel Hill, NC
John V. Rullan, MD, MPH, San Juan, PR
Anne Schuchat, MD, Atlanta, GA
Dixie E. Snider, MD, MPH, Atlanta, GA
John W. Ward, MD, Atlanta, GA

collected information about student dietary intake for the previous 24 hours by using an adaptation of the Child and Adolescent Trial for Cardiovascular Health (CATCH) intervention study's 24-Hour Dietary Recall Interview (*3*). All baseline data were collected in fall 2004, before the pilot program was initiated, and follow-up data were collected in spring 2005, at the end of the school year. Follow-up response rates were 91% for the student survey and 92% for the dietary recall interviews, yielding a final survey sample of 660 students and a final dietary recall interview sample of 191 students (Table 1). All parents provided consent, and all students agreed to participate.

Dietary recall responses were analyzed for fruit and vegetable servings based on the U.S. Department of Agriculture (USDA) Pyramid Servings Database (Version 2) (*4*). Recall data also were analyzed for selected vitamins, minerals, and macronutrients with the Food Intake Analysis System (FIAS), which uses the 1994–1996 and 1998 USDA Continuing Survey of Food Intakes by Individuals (CSFII) nutrient database (*5,6*). Changes in student survey data and dietary recall data between baseline and follow-up were compared using paired *t* tests.

The variety of fruit and vegetables ever eaten increased significantly among students in all three grades (Table 2). However, only 8th-grade students had significant increases in positive attitudes toward eating fruit and vegetables ($p<0.01$), in their beliefs that they could eat more fruit ($p<0.01$), and in their willingness to try new fruit ($p<0.01$). The willingness of 5th-grade students to try new fruit and new vegetables declined significantly ($p=0.01$ and $p=0.03$, respectively), as did their belief that they could eat more vegetables ($p=0.04$).

Changes in degree of student preference for fruit and vegetables also varied by grade. Degree of preference for fruit increased significantly among 8th-grade and 10th-grade students ($p=0.01$ and $p<0.01$, respectively) but decreased significantly among 5th-grade students ($p=0.03$). Degree of preference for vegetables decreased significantly among 5th-grade and 8th-grade students ($p<0.01$ and $p=0.01$, respectively) but remained unchanged among 10th-grade students. Intention to eat fruit increased significantly among 10th-grade students ($p=0.01$) but not among 5th-grade and 8th-grade students. Significant changes in intention to eat vegetables were not detected among students in any of the grades.

Student consumption of fruit in school and overall increased significantly by 0.34 and 0.61 servings per day, respectively ($p<0.01$) (Table 3) among the 8th-grade and 10th-grade students who participated in dietary recall interviews. Student consumption of vegetables in school decreased significantly ($p=0.05$), but consumption of vegetables overall did not change. Intake of vitamin C increased overall, and intake of

TABLE 1. Baseline demographic characteristics of students (n = 660) in grades 5, 8, and 10 who participated in a survey on fruit and vegetables and students (n = 191) in grades 8 and 10 who participated in a 24-hour dietary recall interview — Mississippi Fresh Fruit and Vegetable Pilot Program, 2004–05 school year

	Sex		Race			
Assessment/Grade(s)	Female (%)	Male (%)	Black (%)	White (%)	Other (%)	Mean age (yrs)
Survey/Grade 5 (n = 168)	57.7	42.3	53.0	35.1	11.9	10.4
Survey/Grade 8 (n = 277)	53.1	46.9	76.5	18.4	5.1	13.4
Survey/Grade 10 (n = 215)	51.6	48.4	71.2	27.4	1.4	15.5
Dietary recall interview/Grades 8 and 10 (n = 191)	47.4	52.6	62.0	35.0	3.1	14.4

TABLE 2. Pretest to posttest change in familiarity with, attitudes toward, preferences for, and intentions to eat fruit and vegetables among students (n = 660), by grade and survey topic — Mississippi Fresh Fruit and Vegetable Pilot Program, 2004–05 school year

Topic	Grade	Sample size	Pretest mean score	Posttest mean score	Change*	p value†
Familiarity with fruit and vegetables						
Variety of fruit ever eaten (proportion score§)	5	167	0.85	0.86	+	0.05
	8	274	0.90	0.92	+	<0.01
	10	215	0.89	0.91	+	<0.01
Variety of vegetables ever eaten (proportion score)	5	168	0.61	0.66	+	0.01
	8	271	0.66	0.71	+	<0.01
	10	214	0.64	0.68	+	0.02
Attitudes toward fruit and vegetables						
Positive attitudes toward eating fruit and vegetables (score range: 1–5¶)	5	168	4.10	4.09	NS	0.92
	8	273	4.00	4.11	+	<0.01
	10	213	4.01	4.02	NS	0.83
Student beliefs that they can eat more fruit (score range: 1–5)	5	166	4.38	4.36	NS	0.69
	8	275	4.21	4.41	+	<0.01
	10	213	4.36	4.35	NS	0.90
Student beliefs that they can eat more vegetables (score range: 1–5)	5	166	3.71	3.50	–	0.04
	8	274	3.51	3.52	NS	0.80
	10	214	3.36	3.44	NS	0.30
Willingness to try new fruit (score range: 1–5)	5	167	4.06	3.89	–	0.01
	8	270	3.69	3.86	+	<0.01
	10	212	3.77	3.72	NS	0.37
Willingness to try new vegetables (score range: 1–5)	5	166	3.42	3.22	–	0.03
	8	273	3.13	3.13	NS	0.95
	10	214	3.03	3.08	NS	0.43
Preferences for fruit and vegetables						
Fruit (score range: 0–2¶)	5	167	1.44	1.39	–	0.03
	8	273	1.41	1.44	+	0.01
	10	213	1.32	1.37	+	<0.01
Vegetables (score range: 0–2)	5	166	0.85	0.68	–	<0.01
	8	263	0.73	0.68	–	0.01
	10	199	0.59	0.61	NS	0.39
Intentions to eat fruit and vegetables						
Intentions fruit (score range: 1–4¶)	5	163	3.27	3.21	NS	0.21
	8	275	3.05	3.12	NS	0.07
	10	215	2.98	3.10	+	0.01
Intentions vegetables (score range: 1–4)	5	165	2.55	2.44	NS	0.14
	8	272	2.18	2.16	NS	0.76
	10	211	1.94	2.03	NS	0.07

* A significant positive (+) or negative (–) change in the mean from pretest to posttest. NS = no significant change from pretest to posttest.
† p values from within-group pretest-posttest (no comparison group) paired *t* tests.
§ Number of types of fruit or vegetables that students have ever eaten divided by the total number of types of fruit and vegetables asked about in the survey.
¶ Higher numbers on ranges refer to more positive attitudes and stronger beliefs, more willingness, stronger preferences, and stronger intentions.

TABLE 3. Pretest to posttest change in fruit, vegetables, and nutrients consumed in and consumed in and out of school among students (n = 191) in grades 8 and 10, by food and nutrient — Mississippi Fresh Fruit and Vegetable Pilot Program, 2004–05 school year

	Consumed in school				Consumed in and out of school			
Food/Nutrient	Pretest mean	Posttest mean	Change*	p value†	Pretest mean	Posttest mean	Change	p value
Fruit (servings)	0.49	0.83	+	<0.01	1.01	1.62	+	<0.01
Vegetables (servings)	1.31	0.93	–	0.05	2.80	2.78	NS	0.93
Vitamin A (IU)	996.9	1,269.1	NS	0.18	3,568.1	4,151.6	NS	0.28
Carotene (retinol equivalents)	41.8	73.3	NS	0.11	210.0	273.4	NS	0.22
Vitamin C (mg)	29.7	36.3	NS	0.22	89.7	111.8	+	0.03
Dietary fiber (g)	4.4	5.4	+	0.02	11.9	12.6	NS	0.36
Folate (μg)	108.1	101.4	NS	0.39	337.8	332.6	NS	0.78
Potassium (mg)	1,055.3	1,028.2	NS	0.67	2,444.9	2,456.0	NS	0.92

* A significant positive (+) or negative (–) change in the mean from pretest to posttest. NS = no significant change from pretest to posttest.
† p values from within-group pretest-posttest (no comparison group) paired *t* tests.

dietary fiber increased in school. Consumption of other nutrients did not change significantly.

Reported by: *DJ Schneider, MS, G May, Child Nutrition Program, Mississippi Dept of Education; T Carithers, PhD, Dept of Family and Consumer Sciences, Univ of Mississippi. K Coyle, PhD, S Potter, MS, ETR Associates, Scotts Valley, California. J Endahl, PhD, Office of Analysis, Nutrition, and Evaluation, Food and Nutrition Svcs, US Dept of Agriculture. L Robin, PhD, M McKenna, PhD, K Debrot, DrPH, Div of Adolescent and School Health, J Seymour, PhD, Div of Nutrition and Physical Activity, National Center for Chronic Disease Prevention and Health Promotion, CDC.*

Editorial Note: The results of this evaluation suggest that the Mississippi Fresh Fruit and Vegetable Pilot Program might have helped to increase the variety of fruit and vegetables ever eaten by students in all three grades. The program also might have increased the positive attitudes of 8th-grade students toward eating fruit and vegetables, their willingness to try new types of fruit, and their degree of preference for fruit. Among 10th-grade students, the program might have increased their preferences for fruit and their intentions to eat fruit. Students in the 8th grade expressed significantly less preference for vegetables after the program than before. Students in grades 8 and 10 also increased their consumption of fruit but not vegetables during the school year. Other evaluations of programs to improve fruit and vegetable consumption have noted similar findings (*7*). This program appeared to be more successful with 8th-grade and 10th-grade students than with 5th-grade students, whose reported willingness to try new fruit and vegetables and degree of preference for fruit and vegetables decreased. The findings among 5th-grade students are consistent with results of research on food preferences across the lifespan, which indicates that younger children tend to prefer sweeter, more energy-dense foods (i.e., foods with high calorie content by weight, such as butter) rather than energy-dilute foods (i.e., foods with low calorie content by weight, such as vegetables or plain popcorn), but that these preferences begin to change at puberty (*8*). These results are also consistent with research that indicates that younger children dislike an increasing number of foods as they taste new foods (*9*).

The findings in this report are subject to at least three limitations. First, because of the one-group pretest-posttest design and limited sample size for the dietary recall interviews, the study results do not indicate whether the findings are attributable to the program alone or might have been influenced by seasonality and other unknown trends. Second, the intervention itself was modest in intensity because the only required element was the distribution of fresh fruit and vegetables free of charge to students. Although schools did augment the distribution with various nutrition education activities, the intensity of these activities varied from school to school. Finally, this was a new program for Mississippi schools, many of which experienced start-up and implementation challenges that might have affected the overall impact of the program.

The results of this evaluation suggest that the distribution of fresh fruit at school free of charge to secondary school students might be an effective component of a comprehensive approach for improving student dietary behaviors; however, distribution of fresh vegetables might be more effective with changes in program implementation. Further research is needed to determine the effectiveness of this type of program among youths.

References

1. US Department of Health and Human Services, US Department of Agriculture. Dietary guidelines for Americans, 2005, 6th edition. Washington, DC: US Government Printing Office; January 2005.
2. Krebs-Smith SM, Cook A, Subar A, Cleveland L, Friday J, Kahle LL. Fruit and vegetable consumption intakes of children and adolescents in the United States. Arch Pediatr Adolesc Med 1996;150:81–6.
3. Lytle LA, Nichaman MZ, Obarzanek E, et al. Validataion of 24-hour recalls assisted by food records in third-grade children. The CATCH Collaborative Group. J Am Diet Assoc 1993;93:1431–6.

4. Cook AJ, Friday JE. Pyramid servings database for USDA survey food codes. Version 2.0. Beltsville, MD: US Department of Agriculture, Agricultural Research Service, Community Nutrition Research Group; 2004. Available at http://usna.usda.gov/cnrg/services/foodlink.html#database.
5. University of Texas-Houston. Food Intake Analysis System, Millennium Edition. Houston, TX: University of Texas-Houston School of Public Health; 2005. Available at http://www.sph.uth.tmc.edu/dellcahl/default.asp?id=2146.
6. National Technical Information Service, US Department of Commerce, US Department of Agriculture, Agricultural Research Service. Continuing Survey of Food Intakes by Individuals (CSFII) in 1994–96 and 1998 and the Diet and Health Knowledge Survey (DHKS) in 1994–96. Springfield, VA: US Department of Commerce; 1998. CD-ROM accession no. PB2000-500027.
7. Perry CL, Bishop DB, Taylor G, et al. Changing fruit and vegetable consumption among children: the 5-a-day power plus program in St. Paul, Minnesota. Am J Public Health 1998;88:603–9.
8. Drewnowski A. Sensory control of energy density at different life stages. Proc Nutr Soc 2000;59:239–44.
9. Skinner JD, Carruth BR, Wendy B, Ziegler PJ. Children's food preferences: a longitudinal analysis. J Am Diet Assoc 2002;102:1638–47.

Update: Delayed Onset *Pseudomonas fluorescens* Bloodstream Infections After Exposure to Contaminated Heparin Flush — Michigan and South Dakota, 2005–2006

In March 2005, CDC reported a multistate outbreak of *Pseudomonas fluorescens* bloodstream infections associated with use of syringes preloaded with heparin intravenous catheter flush (*1*). The heparin flush became contaminated during preparation by IV Flush, LLC (Rowlett, Texas). Thirty-six patients in four states were identified who had been exposed to the contaminated flush and subsequently experienced *P. fluorescens* bloodstream infection during December 2004–February 2005 (*1*). Based on a recommendation by the Food and Drug Administration (FDA), IV Flush voluntarily recalled the preloaded syringes in late January (*1*); on January 31 and February 4, 2005, FDA issued nationwide alerts recommending that consumers and institutions stop using and return the preloaded syringes to IV Flush or the distributor (Pinnacle Medical Supply, Rowlett, Texas). Approximately 3 months after the product was recalled, patients in Michigan and South Dakota were identified with *P. fluorescens* bloodstream infections. As of April 2006, a total of 15 patients in Michigan and 13 in South Dakota had been identified with delayed onset *P. fluorescens* bloodstream infections, with occurrences ranging from 84 to 421 days after their last potential exposure to the contaminated flush. The patients all had indwelling central venous catheters and received treatment during October 2005–February 2006 at clinics known to have used the contaminated flush. This report describes the investigation of these cases, which determined that these were delayed onset cases of *P. fluorescens* bloodstream infection from a past exposure to contaminated flush, and provides recommendations for ongoing surveillance for delayed *P. fluorescens* bloodstream infections among similarly exposed patients.

In October 2005, the Michigan Department of Community Health (MDCH) was notified by a hospital infection-control practitioner of a case of *P. fluorescens* bloodstream infection in a woman aged 51 years with breast cancer. She was receiving chemotherapy through an implantable venous port (a type of indwelling central venous catheter) and was being treated at the only Michigan clinic that had used the product manufactured by IV Flush. The patient's bloodstream infection was identified 233 days after her last potential exposure to the contaminated flush. After consultation with CDC, MDCH became aware of additional cases of delayed onset *P. fluorescens* bloodstream infection at the only clinic in South Dakota that had used the implicated flush. After being contacted by MDCH, the South Dakota clinic and the South Dakota Department of Health provided case information.

In this report, a case is defined as illness in a Michigan or South Dakota resident with 1) culture-confirmed *P. fluorescens*[*] bloodstream infection[†] diagnosed during February 4, 2005–March 31, 2006, and 2) who had received treatment at a clinic known to have used the contaminated flush before it was recalled. MDCH requested the Michigan and South Dakota clinics that had used the contaminated flush to review all microbiology records and report all cases of *P. fluorescens* bloodstream infection diagnosed after the product was recalled in January 2005. Medical records of all patients with a diagnosis of *P. fluorescens* bloodstream infection were reviewed, with a focus on determining last potential exposure to the contaminated heparin flush.

Local and state laboratories recovered *P. fluorescens* isolates from blood samples provided by the clinics and hospital emergency departments. CDC laboratories tested catheters that had been removed surgically from the patients and shipped to CDC with assistance from the health departments; in some instances, *P. fluorescens* bloodstream infection had already been diagnosed after a positive blood culture, and in others, blood cultures were negative for patients who had known exposures

[*] Including two patients with isolates identified as *Pseudomonas fluorescens-putida* group.
[†] Confirmation of *P. fluorescens* presence through positive blood or catheter culture in a symptomatic patient (e.g., a patient with at least one of the following signs or symptoms: chills, fever, nausea, or vomiting).

to the contaminated flush and later had onset of bloodstream infection symptoms. Catheter sections were prerinsed to remove nonadherent cells and cultured for the presence of *P. fluorescens* biofilms. CDC compared blood and catheter isolates by using pulsed-field gel electrophoresis (PFGE) and used scanning electron microscopy to confirm the presence of *P. fluorescens* biofilms.

A total of 28 patients from Michigan and South Dakota had illness consistent with the case definition, with diagnosis dates ranging from April 29, 2005, to March 10, 2006. Median age was 58 years (range: 24–79 years). Twenty (71%) patients were female. All had cancer and were outpatients with implantable venous ports. Of the 28 patients, 27 (96%) experienced chills ≤8 hours after receiving a port flushing (i.e., with uncontaminated flush); other signs and symptoms included fever in 14 (50%) patients and nausea or vomiting in 10 (36%). Twenty-two (79%) patients were treated with oral antibiotics; some received antibiotics when bloodstream infection was suspected because of clinical symptoms (especially if they had been to an emergency department) or when they had a positive blood culture. Because some patients had negative blood cultures and did not receive diagnoses until catheter removal and culture, they received antibiotics later. All 28 had their ports (i.e., catheters) removed surgically. No deaths were reported. The mean time from last potential exposure to the contaminated flush until diagnostic specimen collection was 237 days (range: 84–421 days).

P. fluorescens was recovered from port catheters in 17 (81%) of 21 patients,[§] from blood cultures in 15 (79%) of 19 patients, and from both blood and catheter cultures in four (33%) of 12 patients. PFGE was performed on 19 available *P. fluorescens* isolates from blood or catheter cultures. PFGE patterns indicated that all 19 isolates were genetically indistinguishable from or closely related to isolates from the March 2005 investigation (*1*). Catheter specimens were sent to CDC for examination by scanning electron microscopy, which indicated the presence of biofilms with bacilli adhering to catheter lumens.

On-site investigations in Michigan and South Dakota confirmed that the clinics were no longer using and had returned the recalled flush. Cultures of the new flush being used in Michigan and South Dakota did not recover any organisms. Surveillance for additional cases of delayed onset *P. fluorescens* bloodstream infection continues at the Michigan and South Dakota clinics described in this report. IV Flush, the manufacturer of the contaminated product, has ceased operation.

Reported by: *J McHale, Sioux Falls; J Clayton, South Dakota Dept of Health. C Kim, MD, Univ of Michigan School of Public Health; M Wilkins, DVM, E Wells, MD, J Rudrik, PhD, Michigan Dept of Community Health. MJ Arduino, DrPH, J Noble-Wang, PhD, B Jensen, MMSc, J Carr, A Srinivasan, MD, Div of Healthcare Quality Promotion, National Center for Preparedness, Detection, and Control of Infectious Diseases (proposed); M Gershman, MD, EIS Officer, CDC.*

Editorial Note: This report describes the first known cases of substantially delayed bloodstream infections (i.e., 84–421 days) after exposure to a contaminated intravenous solution. PFGE analysis linking *P. fluorescens* isolates from the current investigation both to one another and to those of the original investigation (March 2005) confirmed that these were delayed onset cases from past exposure to the contaminated heparin flush.

P. fluorescens is an aerobic, gram-negative bacterial rod that grows best at temperatures of approximately 77°F–86°F (25°C–30°C) and grows poorly at the standard hospital microbiology incubation temperature of approximately 97°F (36°C) (*1*,*2*). Therefore, identification of *P. fluorescens* can be difficult, depending on laboratory capabilities. The bacteria typically thrive in moist environments (including water, soil, and foods) and are not a frequent cause of human infections. However, *P. fluorescens* has been reported to cause occasional cases of transfusion-associated septicemia in blood recipients, including fatal reactions (*3*), and catheter-related bacteremia in patients with cancer (*4*).

At least four factors contributed to the delayed onset of symptoms and diagnosis of bloodstream infection in the patients described. First, *P. fluorescens* colonized catheter lumens by forming biofilms (as confirmed by electron microscopy at CDC); previous electron microscopy studies have indicated that nearly all indwelling vascular catheters become colonized by microorganisms embedded in a biofilm layer (*5*). Biofilm is composed of these microorganisms and a structural matrix of extracellular polymers, primarily polysaccharides, produced by the microorganisms. *P. fluorescens* in the contaminated heparin flush either colonized preexisting catheter lumen biofilms or initiated new biofilm formation; heparin might have stimulated biofilm formation, which has been reported in vitro with another bacterial species (*6*). Although *P. fluorescens* might not have entered patient bloodstreams in sufficient quantities to cause symptoms on initial exposure to the contaminated flush, biofilm formation enabled the bacteria to persist in patient port catheters. The bacteria might have proliferated in the biofilm, from which they were disrupted by subsequent, uncontaminated flushes and released into the bloodstream, finally causing symptoms. Second, 12 patients who were no longer receiving chemotherapy received catheter flushes infrequently and consequently did not have frequent flush-related bloodstream infection symptoms. Third, patients still receiving chemotherapy ini-

[§] The remaining seven catheters either were discarded by surgeons or hospital laboratorians before they could be transported to CDC or were available but not sent.

tially assumed bloodstream infection symptoms were chemotherapy side effects because some symptoms are similar. Finally, isolating *P. fluorescens* from clinical specimens initially was difficult because of its growth requirements.

The data in this report are subject to at least four limitations. First, cases might have been missed because of false-negative blood cultures at local laboratories. Second, information on South Dakota cases might be inaccurate or incomplete because investigators in Michigan performed South Dakota chart reviews by proxy. Third, recall bias might have resulted in incomplete or inaccurate information from patients regarding symptoms (e.g., type, onset date, or timing of onset relative to flushes). Finally, the case-finding methods varied between the South Dakota and Michigan clinics.

The data in this report indicate that patients with implantable venous ports who receive heparin flushes contaminated with *P. fluorescens* are at risk for bloodstream infection up to 14 months after last receiving the contaminated flush. Subsequent episodic catheter flushing with uncontaminated flush might physically disrupt biofilms causing symptomatic, intermittent bacteremia. Health-care providers should conduct ongoing surveillance and be aware of possible bloodstream infection in patients with indwelling catheters who have received contaminated injections, even several months after exposure. Catheter removal in such instances is strongly recommended, especially among immunocompromised patients, because antibiotic therapy alone might not eradicate *P. fluorescens* from catheter biofilms. Providers should alert laboratories when bacterial species with atypical growth requirements are suspected clinically.

Acknowledgment

This report is based, in part, on data contributed by C Abuel, T Peer, PJ Powers, Osteopathic Medical Oncology and Hematology (clinic), Michigan.

References

1. CDC. *Pseudomonas* bloodstream infections associated with a heparin/saline flush—Missouri, New York, Texas, and Michigan, 2004–2005. MMWR 2005;54:269–72.
2. Weyant RS, Moss CW, Weaver RE, et al. Identification of unusual pathogenic gram-negative aerobic and facultatively anaerobic bacteria. 2nd ed. Baltimore, MD: Williams & Wilkins;1996.
3. Scott J, Boulton FE, Govan JR, Miles RS, McClelland DB, Prowse CV. A fatal transfusion reaction associated with blood contaminated with *Pseudomonas fluorescens*. Vox Sang 1988;54:201–4.
4. Hsueh PR, Teng LJ, Pan HJ, et al. Outbreak of *Pseudomonas fluorescens* bacteremia among oncology patients. J Clin Microbiol 1998;36:2914–7.
5. Raad I. Intravascular-catheter-related infections [seminar]. Lancet North Am Ed 1998;351:893–8.
6. Shanks RM, Donegan NP, Graber ML, et al. Heparin stimulates *Staphylococcus aureus* biofilm formation. Infec Immun 2005;73:4596–606.

Measles Outbreak and Response — Fiji, February–May 2006

In September 2005, the 37 countries and areas of the World Health Organization (WHO) Western Pacific Region (WPR) established a goal to eliminate measles in the region by 2012. After multiple outbreaks in 1996 and 1997, measles supplementary immunization activities (SIAs) in 1997 and 1998 resulted in apparent interruption of measles transmission in WPR. Since then, importations have resulted in limited outbreaks in French Polynesia and Guam, a large outbreak in the Marshall Islands in 2003, and an outbreak in Fiji during February–May 2006. This report describes the epidemiologic findings, public health response, and potential causes of the 2006 outbreak that produced 132 measles cases in Fiji (2006 estimated population: 832,432), the most populous country in the South Pacific.

Background

To achieve and sustain measles elimination and prevent importation-associated outbreaks, the WPR office of WHO recommends that countries achieve and maintain vaccination coverage of ≥95% with 2 doses of measles vaccine in every district. The WPR office further recommends that countries ensure measles surveillance that 1) detects one or more suspected measles cases per 100,000 population per year in ≥80% of districts, 2) tests serum samples from ≥80% of persons with suspected measles, and 3) obtains a viral isolate from every chain of measles transmission (*1*).

Fiji's Expanded Program on Immunization introduced measles vaccine in 1982 as a single dose for children aged 9 months. From 1982 to 1998, reported routine measles vaccination coverage increased from 20% to 80%. Measles SIAs were conducted in 1998, targeting children aged 9 months–14 years and achieving an administrative vaccination coverage rate* of 85%, and in 2001, targeting children aged 9 months–5 years and achieving an administrative coverage of 86%.

In 2003, Fiji introduced a 2-dose schedule for measles-rubella vaccine, with doses administered at ages 1 year and 6 years, the latter at school entry. An SIA with measles-rubella vaccine targeting children aged 6–11 years was conducted during 2003–2004; administrative vaccination coverage was not reported. During 2001–2004, routine vaccination coverage with 1 dose of measles-rubella vaccine averaged 83% annu-

* Calculated by dividing the number of doses of vaccine reported administered through the immunization campaign by the number of persons in the target population.

ally. Findings from a 2005 survey of children aged 12–23 months indicated nationwide vaccination coverage of 80% with 1 dose of measles-rubella vaccine, although pockets of lower coverage were identified.

Before 2006, the last laboratory-confirmed measles outbreak in Fiji occurred during September 1997–April 1998, when 955 measles cases were reported, of which 86% were in children aged <15 years. Since late 1998, Fiji had been considered measles-free. Isolated clinical measles cases had been reported, and rubella, but not measles, had been confirmed by laboratory testing.

Outbreak

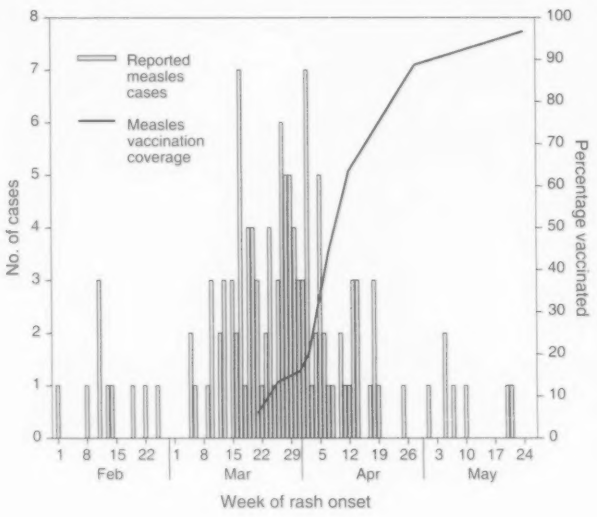
On February 17, 2006, the Ministry of Health (MOH) in Fiji received a report of three infants, with rash onsets on February 8 and 11, who had been admitted to a divisional hospital because of suspected measles and pneumonia. The three infants lived near the international airport at Nadi in the Western Division. On February 23, measles was confirmed by serologic testing for the presence of anti-measles virus immunoglobulin M (IgM) at the national laboratory in Fiji and verified on February 28 by the WHO Measles Regional Reference Laboratory at the Victorian Infectious Diseases Reference Laboratory in Australia, where an isolate was identified as measles genotype H1.

During February 17–June 9, a total of 132 suspected measles cases were reported to MOH, including 22 that were laboratory confirmed (anti-measles virus IgM positive) (Figure). Among the 132 measles patients, 119 (90%) resided in the Western Division and 13 (10%) in the Central and Eastern divisions. Within the Western Division, one subdivision had 58 (44%) of the measles cases. Routine vaccination coverage with 1 dose of measles-rubella vaccine in this subdivision had been reported as 49% in 2004 and 68% in 2005. A total of 76 (58%) patients were aged <5 years; the highest incidence (378 cases per 100,000 population) was among children aged 6–11 months (Table). Thirty-one (23%) patients required hospitalization; no deaths were reported. For 41 children aged 12–59 months for whom MOH could obtain detailed case investigation data, 12 (29%) had received 1 dose of measles-rubella vaccine, 10 (24%) had not been vaccinated, and 19 (46%) had unknown vaccination status. As of August 8, no additional laboratory-confirmed measles cases had been reported with rash onset after May 21.

Outbreak Control Measures

Enhanced surveillance. Reporting of acute fever and rash cases was intensified in Fiji's 21-hospital sentinel surveillance network, initially created for acute flaccid paralysis surveillance as part of the global poliomyelitis eradication initiative. Daily telephone calls were made to all sentinel hospitals for reports on new patients. Illnesses with rash and fever were confirmed as measles if they met the WHO measles clinical case definition.[†] To encourage case reporting, the national coordinator of the Expanded Program on Immunization pro-

FIGURE. Number of reported measles cases and percentage of children* vaccinated during outbreak-response immunization campaign, by week of rash onset — Fiji, 2006



* Aged 6 months to <6 years.

TABLE. Number, percentage, and incidence rate* of reported measles cases, by age group — Fiji, February 17–June 9, 2006

Age group	No. of cases	% of total cases	Total population	Incidence rate
<6 mos	5	3.8	8,784	57
6–11 mos	33	25.0	8,722	378
1–4 yrs	38	28.8	69,475	55
5–9 yrs	10	7.6	95,049	11
10–14 yrs	10	7.6	101,499	10
15–19 yrs	8	6.1	91,654	9
20–24 yrs	3	2.3	73,323	4
25–29 yrs	14	10.6	67,552	21
30–34 yrs	5	3.8	66,618	8
≥35 yrs	6	4.5	249,756	2
Total	**132**	**100.0**	**832,432**	**16**

* Per 100,000 population in age group, during February 17–June 9, 2006.

[†] Fever with rash and at least one of the following: cough, coryza, or conjunctivitis.

vided daily surveillance summaries by e-mail and fax to all hospitals, selected health centers, and partner agencies.

Case management. Triage and measles treatment recommendations, based on WHO Integrated Management of Childhood Illnesses guidelines (*2*), were distributed to all health facilities and health workers to ensure that suspected measles cases were managed appropriately and to prevent measles virus transmission in health-care facilities. Vitamin A, a key part of WHO case-management guidelines to reduce measles morbidity and mortality, was distributed in capsules to all hospitals and health centers in late March.

Social mobilization. A multiphase social mobilization and communication plan was developed using WHO's Communication-for-Behavioral-Impact approach (*3*), to prompt individual and family action. The initial phase, "Beware," informed the public about the measles outbreak and promoted reporting of suspected cases. The second phase, "Vaccinate," promoted an immunization campaign, prompting parents and guardians to bring children in the targeted age group to vaccination sites made visible by large banners. Activities included distribution of 60,000 fact sheets to schools and community and religious organizations, announcements on television and radio, and advertisements in cinemas and newspapers.

Outbreak-response immunization (ORI). To protect children in the age groups accounting for >60% of cases and most at risk for severe outcomes, 91,595 children aged 6 months to <6 years were targeted with measles-rubella vaccine during March 20–May 3, 2006. A goal of ≥95% vaccination coverage was set for all administrative levels. Plans at the subdivisional level were developed for budget estimates and distribution of bundled vaccine and injection-safety items.[§] Campaign training workshops, including classes on vaccination safety, were conducted for health-care workers throughout the country. Vaccination-coverage rates with measles-rubella vaccine were reported twice weekly from all vaccination sites to promptly identify areas needing external assistance. Rapid vaccination-coverage monitoring, using a 20-household convenience sample format, was conducted in urban and other areas at risk for measles. If two or more homes contained unvaccinated children, the area was targeted for repeat vaccinations. Of 32 areas surveyed, 12 (38%) required follow-up.

MOH subsequently reported that 89,747 (98%) of targeted children had received measles-rubella vaccine as of May 24. Among 20 Fijian subdivisions, two had reported coverage <95%: Suva (91%) in the Central Division and Macuata (90%) in the Northern Division. No serious adverse events from vaccination were reported.

Reported by: *S Samuela, T Tuiketei, Ministry of Health, Fiji. R Duncan, T Kubo, J Kool, K Chen, South Pacific Office; E Smith, M Hercules, Y Baoping, Western Pacific Regional Office; Vaccines and Biologicals Dept, WHO, Geneva, Switzerland. Global Immunization Div, National Center for Immunization and Respiratory Diseases (proposed), CDC.*

Editorial Note: The measles outbreak in Fiji described in this report, like the 2003 outbreak in the Marshall Islands, underscores that absence of measles virus transmission should not create a false sense of security and that high population immunity is essential to preventing future outbreaks (*4*). As an island, Fiji's isolation from countries where measles is endemic, combined with its small population, likely contributed to the lack of reported measles cases from late 1998 through 2005 (*5,6*). Low routine vaccination coverage, combined with persistent pockets of susceptible adolescents and adults despite previous SIAs and outbreaks, might have left the country vulnerable to an outbreak via importation.

Achieving ≥95% population immunity (i.e., through high vaccination coverage with 2 doses of measles vaccine) will halt measles transmission within a population (*7*). In Fiji, the high incidence of measles in a single subdivision with historically low routine measles vaccination coverage and the occurrence of measles in all age groups highlight the importance of monitoring measles vaccination coverage at subnational levels and in older age groups (i.e., aged >15 years) to ensure that pockets of measles susceptibility do not develop.

The first identified cases of measles in this outbreak were in children already hospitalized with pneumonia. Because recognition of measles might decrease after measles virus transmission has been interrupted for long periods, national programs should remind clinicians to be vigilant and to report suspected cases, particularly in areas of low vaccination coverage. To increase sensitivity and timeliness of surveillance, primary-care facilities and outpatient departments might be included as reporting sites, and community-based informants used to report suspected measles cases.

The findings in this report are subject to at least three limitations. First, surveillance was conducted through sentinel site reporting and, as a result, all suspected measles cases might not have been reported. Second, not all suspected measles cases were laboratory confirmed; therefore, some suspected cases might have had etiologies other than measles. Finally, the estimated vaccination coverage achieved in the ORI was based on administrative data. Because uncertainties often exist regarding the denominator used to calculate administrative coverage, these data generally are less reliable than survey-based coverage estimates.

[§] Bundling of vaccine, diluent, auto-disable syringes, vaccine-reconstitution syringes, and safety boxes.

Targeting children aged 6 months to <6 years during the ORI was important because this group accounted for >60% of cases and was more vulnerable to severe measles outcomes. The Fijian MOH rapidly achieved high vaccination coverage with measles vaccine. At the same time, a sharp decrease in reported cases among all age groups occurred. The effectiveness of the ORI is greater when the intervention occurs early in the course of an outbreak (*8*). In Fiji, the campaign began 6 weeks after the first case was reported; 8 weeks later, the last case was reported. The commitment by MOH and its partners to reach ≥95% of targeted children was essential to interrupting measles virus transmission and preventing spread of the measles virus to other vulnerable Pacific Islands.

References

1. World Health Organization, Regional Office for the Western Pacific. Field guidelines for measles elimination. Geneva, Switzerland: World Health Organization; 2004. Available at http://www.wpro.who.int.
2. Integrated management of childhood illnesses: IMCI planning guide: gaining experience with the IMCI strategy in a country. Geneva, Switzerland: World Health Organization; 1999. Available at http://www.who.int/child-adolescent-health.
3. World Health Organization, Mediterranean Centre for Vulnerability Reduction (WMC), Tunis, Tunisia. Mobilising for healthy behaviour. Geneva, Switzerland: World Health Organization; 2003. Available at http://wmc.who.int/strategic/mobilising/index.html.
4. Hyde TB, Dayan G, Langidrik JR, et al. Measles outbreak in the Republic of the Marshall Islands, 2003. Int J Epidemiol 2006;35:299–306.
5. Rhodes CJ, Butler AR, Anderson RM. Epidemiology of communicable diseases in small populations. J Mol Med 1998;76:111–6.
6. Black FL. Measles endemicity in insular populations: critical community size and its evolutionary implications. J Theor Biol 1966;11:207–11.
7. Gay NJ. The theory of measles elimination: implications for the design of elimination strategies. J Infect Dis 2004;189(Suppl 1):S27–35.
8. Guris D, Auerbach SB, Vitek C, et al. Measles outbreaks in Micronesia, 1991 to 1994. Pediatr Infect Dis J 1998;17:33–9.

Notice to Readers

Public Health Notification Regarding Concern Over Recovered Human Tissues — United States, 2006

On August 30, 2006, the Food and Drug Administration (FDA) issued a Public Health Notification* to inform the health-care community that human tissues, recovered by a tissue recovery company called Donor Referral Services (DRS) (Raleigh, North Carolina) and subsequently used in transplant procedures, might not have met FDA requirements for donor eligibility. Tissue products used for transplantation typically include bone, demineralized bone matrix, skin, and soft tissue (e.g., tendons) (*1*).

On August 18, FDA issued to DRS an Order to Cease Manufacturing and to Retain Human Cells, Tissues and Cellular and Tissue-Based Products.† Since then, an ongoing FDA investigation has obtained additional information regarding manufacturing and blood-screening practices at DRS that has heightened concern for all recipients of tissue recovered by DRS. The four tissue banks that received and distributed tissue initially recovered by DRS have conducted recalls: Alamo Tissue Services (San Antonio, Texas); Lost Mountain Tissue Bank (Kennesaw, Georgia); TissueNet of Orlando, Florida; and U.S. Tissue and Cell (USTC) (Cincinnati, Ohio; Allosource [Centennial, Colorado] acquired USTC in March 2006 and is performing all recall and physician notification activities for USTC). These four firms have voluntarily recalled all unused tissues remaining in inventory and continue to work with FDA to notify health-care facilities that received these tissues so that health-care providers can inform their patients who received transplants and offer testing.

No adverse reactions related to these tissue transplants have been reported to FDA. After recovery by DRS, the tissues underwent processing steps at other sites that are designed to reduce the risk for disease transmission. However, because the actual risk for infection is unknown, FDA and CDC strongly recommend that health-care providers inform their patients who received tissues recovered by DRS that assessment of eligibility of the tissue donors might not have been performed adequately. In addition, FDA and CDC recommend that health-care providers offer patients access to appropriate testing for infectious diseases. The relevant communicable diseases for which a tissue donor is required to be tested are human immunodeficiency virus (HIV)-1 and HIV-2, hepatitis B virus, hepatitis C virus, and syphilis. Health-care facilities that received tissues from DRS should notify clinicians who implanted the tissues so that patient notifications can be initiated. Further information regarding tissue transplants and specific testing recommendations is available at http://www.cdc.gov/ncidod/dhqp/tissuetransplantsfaq.html.

State and local health department officials who seek to determine whether tissues recovered by DRS were distributed to facilities in their jurisdictions should contact the four tissue banks identified. Health-care providers who have concerns or questions about the source of their patients' tissue transplants should contact the health-care facilities where the procedures were performed. Tissue recipients who are concerned that they might have received tissue recovered by DRS should contact the health-care providers who performed their implants.

* Available at http://www.fda.gov/cber/safety/drs083006.htm.

† Available at http://www.fda.gov/cber/compl/drs081806.htm.

FDA's Current Good Tissue Practice Rules,[§] effective May 25, 2005, require manufacturers to prevent introduction, transmission, or spread of infectious diseases through human cells, tissue, and cellular and tissue-based products. On August 30, 2006, FDA announced formation of a Human Tissue Task Force[¶] to assess the effectiveness of the implementation of these new tissue regulations, to review recently reported findings that certain recovery establishments were not following federal requirements for tissue recovery, and to develop an action plan for proposed changes to existing policies. Health-care providers should report any adverse reaction that might be related to a tissue transplant to the appropriate processing or distributing firms; patients with suspected adverse reactions should contact their health-care providers or the health-care facilities where the procedures were performed. These reactions also should be reported to FDA's MedWatch system (by telephone, 800-FDA-1088; fax, 800-FDA-0178; mail, MedWatch, Food and Drug Administration, 5600 Fishers Lane, Rockville, MD 20857-9787; or online, http://www.fda.gov/medwatch). Adverse reactions also can be reported to CDC by telephone, 800-893-0485, or to state or local health departments.

Reference

1. CDC. Investigation into recalled human tissue for transplantation—United States, 2005–2006. MMWR 2006;55:564–6.

[§] Available at http://www.fda.gov/bbs/topics/news/2004/new01137.html.
[¶] Available at http://www.fda.gov/bbs/topics/news/2006/new01440.html.

Notice to Readers

World Suicide Prevention Day

September 10 is World Suicide Prevention Day. Suicide was the 11th overall leading cause of death in the United States in 2003 (the most recent year for which final death data are available) and was responsible for 31,484 deaths (*1*), which equates to one suicide every 17 minutes. In addition, suicide attempts and other acts of self-harm that result in nonfatal injuries affect the health of many persons and families. In 2004 (the most recent year for which final ambulatory hospital data are available), approximately 535,000 visits to U.S. emergency departments were made after attempted suicides or because of other self-inflicted injuries (*2*).

Reducing the overall suicide rate of the population and the number of suicide attempts among adolescents are two of the 2010 national health objectives (objectives 18-1 and 18-2, respectively) (*3*). Integrated prevention strategies that address multiple relevant topics (e.g., substance-abuse prevention, family and peer support, and access to health services) are likely to be more effective in reducing suicidal behavior than programs that focus on a single factor (*4*). Additional information about suicide prevention is available from the National Center for Injury Prevention and Control at http://www.cdc.gov/injury. Additional information about World Suicide Prevention Day is available at http://www.med.uio.no/iasp.

References

1. Hoyert DL, Heron MP, Murphy SL, Kung H. Deaths: final data for 2003. Natl Vital Stat Rep 2006;54(13).
2. McCaig LF, Nawar EN. National hospital ambulatory medical care survey: 2004 emergency department summary. Advance data from vital and health statistics; no 372. Hyattsville, MD: National Center for Health Statistics; 2006.
3. US Department of Health and Human Services. Healthy people 2010, 2nd ed. With understanding and improving health and objectives for improving health. 2 vols. Washington, DC: US Government Printing Office; 2000.
4. Goldsmith SK, Pellmar TC, Kleinman AM, Bunney WE, eds. Reducing suicide: a national imperative. Washington, DC: National Academies Press; 2002.

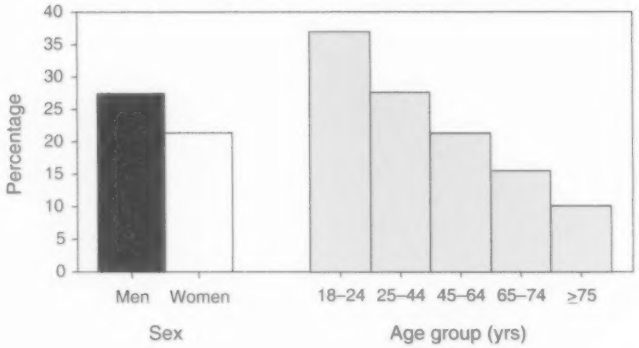
Erratum: Vol. 55, No. 34

The following error occurred in certain copies of the *MMWR* issue dated September 1, 2006. In the report, "Youth Exposure to Alcohol Advertising on Radio — United States, June–August 2004," an error occurred in the second footnote to Tables 1 and 2 on pages 939 and 940, respectively. The footnote should read: "The > proportion than local population programs were those in which the proportion of the audience aged 12–20 years was **greater than** the proportion of those aged 12–20 years in the general population of the local market. >15% programs were those in which >15% of listeners were aged 12–20 years. >30% programs were those in which >30% of listeners were aged 12–20 years."

QuickStats

FROM THE NATIONAL CENTER FOR HEALTH STATISTICS

Percentage of Adults* Who Engaged in Any Leisure-Time Strengthening Activity,† by Sex and Age Group — United States, 2005



* Aged ≥18 years.
† Data are based on household interviews of a sample of the civilian, noninstitutionalized population. Participants were asked: "How often do you do leisure-time physical activities specifically designed to strengthen your muscles such as lifting weights or doing calisthenics?"

In 2005, approximately one fourth of all adults reported participating in any leisure-time strengthening activity, a component of overall physical fitness. Men were more likely than women to engage in leisure-time strengthening activities. The percentage of adults who engaged in these activities decreased with age, from 37% among persons aged 18–24 years to 10% among persons aged ≥75 years.

SOURCE: National Health Interview Survey, 2005. Available at http://www.cdc.gov/nchs/nhis.htm.

TABLE I. Provisional cases of infrequently reported notifiable diseases (<1,000 cases reported during the preceding year) — United States, week ending September 2, 2006 (35th Week)*

Disease	Current week	Cum 2006	5-year weekly average†	Total cases reported for previous years 2005	2004	2003	2002	2001	States reporting cases during current week (No.)
Anthrax	—	1	—	—	—	—	2	23	
Botulism:									
foodborne	—	3	1	19	16	20	28	39	
infant	1	58	2	90	87	76	69	97	TN (1)
other (wound & unspecified)	1	42	1	33	30	33	21	19	CA (1)
Brucellosis	1	67	2	122	114	104	125	136	GA (1)
Chancroid	—	20	1	17	30	54	67	38	
Cholera	—	5	0	8	5	2	2	3	
Cyclosporiasis§	4	86	4	734	171	75	156	147	GA (1), FL (3)
Diphtheria	—	—	0	—	—	1	1	2	
Domestic arboviral diseases§,¶:									
California serogroup	—	12	8	78	112	108	164	128	
eastern equine	—	4	1	21	6	14	10	9	
Powassan	—	1	—	1	1	—	1	N	
St. Louis	—	2	4	10	12	41	28	79	
western equine	—	—	—	—	—	—	—	—	
Ehrlichiosis§:									
human granulocytic	5	229	13	790	537	362	511	261	NY (2), GA (2), FL (1)
human monocytic	3	235	10	522	338	321	216	142	NY (1), NC (1), SC (1)
human (other & unspecified)	1	70	2	122	59	44	23	6	MD (1)
Haemophilus influenzae,**									
invasive disease (age <5 yrs):									
serotype b	—	5	1	9	19	32	34	—	
nonserotype b	—	57	3	135	135	117	144	—	
unknown serotype	1	137	2	217	177	227	153	—	PA (1)
Hansen disease§	1	43	1	88	105	95	96	79	NH (1)
Hantavirus pulmonary syndrome§	—	21	0	29	24	26	19	8	
Hemolytic uremic syndrome, postdiarrheal§	5	120	6	221	200	178	216	202	MN (1), TN (2), CA (2)
Hepatitis C viral, acute	5	513	33	771	713	1,102	1,835	3,976	NY (1), NE (1), KS (1), TN (1), CA (1)
HIV infection, pediatric (age <13 yrs)§,††	—	52	4	380	436	504	420	543	
Influenza-associated pediatric mortality§,§§,¶¶	—	41	0	49	—	N	N	N	
Listeriosis	11	391	19	892	753	696	665	613	ME (1), NY (1), PA (2), OH (1), IN (1), NC (1), SC (1), FL (1), CA (2)
Measles	—***	31	1	66	37	56	44	116	
Meningococcal disease,††† invasive:									
A, C, Y, & W-135	1	147	3	297	—	—	—	—	NY (1)
serogroup B	—	98	1	157	—	—	—	—	
other serogroup	—	13	0	27	—	—	—	—	
Mumps	7	5,587	5	314	258	231	270	266	MI (1), KS (2), FL (1), CA (3)
Plague	—	7	0	8	3	1	2	2	
Poliomyelitis, paralytic	—	—	—	1	—	—	—	—	
Psittacosis§	2	15	0	19	12	12	18	25	PA (1), CA (1)
Q fever§	—	97	1	139	70	71	61	26	
Rabies, human	—	1	0	2	7	2	3	1	
Rubella	—	6	0	11	10	7	18	23	
Rubella, congenital syndrome	—	1	—	1	—	1	1	3	
SARS-CoV§,§§	—	—	—	—	—	8	N	N	
Smallpox§	—	—	—	—	—	—	—	—	
Streptococcal toxic-shock syndrome§	—	73	1	129	132	161	118	77	
Streptococcus pneumoniae,§									
invasive disease (age <5 yrs)	5	731	6	1,257	1,162	845	513	498	OH (1), MN (1), OK (2), TX (1)
Syphilis, congenital (age <1 yr)	—	168	8	361	353	413	412	441	
Tetanus	—	15	1	27	34	20	25	37	
Toxic-shock syndrome (other than streptococcal)§	2	63	2	96	95	133	109	127	NY (1), OH (1)
Trichinellosis	1	10	0	19	5	6	14	22	FL (1)
Tularemia§	—	55	4	154	134	129	90	129	
Typhoid fever	5	178	10	324	322	356	321	368	NY (1), FL (2), CA (2)
Vancomycin-intermediate *Staphylococcus aureus*§	—	2	0	2	—	N	N	N	
Vancomycin-resistant *Staphylococcus aureus*§	—	—	—	3	1	N	N	N	
Yellow fever	—	—	—	—	—	—	1	—	

—: No reported cases. N: Not notifiable. Cum: Cumulative year-to-date counts.

* Incidence data for reporting years 2005 and 2006 are provisional, whereas data for 2001, 2002, 2003, and 2004 are finalized.

† Calculated by summing the incidence counts for the current week, the two weeks preceding the current week, and the two weeks following the current week, for a total of 5 preceding years. Additional information is available at http://www.cdc.gov/epo/dphsi/phs/files/5yearweeklyaverage.pdf.

§ Not notifiable in all states.

¶ Includes both neuroinvasive and non-neuroinvasive. Updated weekly from reports to the Division of Vector-Borne Infectious Diseases, National Center for Zoonotic, Vector-Borne, and Enteric Diseases (proposed) (ArboNET Surveillance).

** Data for *H. influenzae* (all ages, all serotypes) are available in Table II.

†† Updated monthly from reports to the Division of HIV/AIDS Prevention, National Center for HIV, Viral Hepatitis, STDs, and Tuberculosis Prevention (proposed). Implementation of HIV reporting influences the number of cases reported. Data for HIV/AIDS are available in Table IV quarterly.

§§ Updated weekly from reports to the Division of Viral and Rickettsial Diseases, National Center for Zoonotic, Vector-Borne, and Enteric Diseases (proposed).

¶¶ A total of 46 cases were reported since the beginning of the 2005-06 flu season (October 2, 2005 [week 40]).

*** No measles cases were reported for the current week.

††† Data for meningococcal disease (all serogroups and unknown serogroups) are available in Table II.

TABLE II. Provisional cases of selected notifiable diseases, United States, weeks ending September 2, 2006, and September 3, 2005 (35th Week)*

Reporting area	Chlamydia† Current week	Chlamydia† Previous 52 weeks Med	Chlamydia† Previous 52 weeks Max	Chlamydia† Cum 2006	Chlamydia† Cum 2005	Coccidioidomycosis Current week	Coccidioidomycosis Previous 52 weeks Med	Coccidioidomycosis Previous 52 weeks Max	Coccidioidomycosis Cum 2006	Coccidioidomycosis Cum 2005	Cryptosporidiosis Current week	Cryptosporidiosis Previous 52 weeks Med	Cryptosporidiosis Previous 52 weeks Max	Cryptosporidiosis Cum 2006	Cryptosporidiosis Cum 2005
United States	9,450	18,737	35,170	624,122	646,296	22	149	1,643	5,625	2,740	117	66	860	2,341	3,500
New England	554	617	1,550	21,122	21,662	—	0	0	—	—	—	4	35	155	179
Connecticut	—	169	1,214	5,702	6,578	N	0	0	N	N	—	0	17	17	27
Maine§	43	44	74	1,494	1,462	N	0	0	N	N	—	0	3	21	20
Massachusetts	431	287	448	9,811	9,501	—	0	0	—	—	—	2	15	63	82
New Hampshire	25	36	64	1,253	1,213	—	0	0	—	—	—	1	3	18	21
Rhode Island	55	63	95	2,130	2,251	—	0	0	—	—	—	0	6	7	5
Vermont§	—	19	43	732	657	N	0	0	N	N	—	0	5	29	24
Mid. Atlantic	1,163	2,378	3,696	78,338	78,648	—	0	0	—	—	14	10	597	311	1,299
New Jersey	167	357	500	11,963	13,069	N	0	0	N	N	—	0	8	9	36
New York (Upstate)	505	499	1,727	15,843	15,671	N	0	0	N	N	11	3	561	99	1,040
New York City	—	748	1,584	24,360	25,254	N	0	0	N	N	—	2	15	41	84
Pennsylvania	491	755	1,075	26,172	24,654	N	0	0	N	N	3	5	21	162	139
E.N. Central	1,239	3,116	12,578	103,279	108,023	1	0	3	32	5	12	16	162	598	696
Illinois	432	967	1,686	33,721	33,835	—	0	0	—	—	—	2	13	61	99
Indiana	297	403	552	13,298	13,368	N	0	0	N	N	2	1	13	41	38
Michigan	364	614	9,888	21,373	17,664	1	0	3	28	5	—	2	7	77	68
Ohio	48	716	1,446	22,095	29,658	—	0	1	4	—	10	5	109	214	196
Wisconsin	98	398	531	12,792	13,498	N	0	0	N	N	—	5	38	205	295
W.N. Central	285	1,144	1,456	37,907	39,657	—	0	12	—	4	27	11	42	394	416
Iowa	143	155	225	5,467	4,755	N	0	0	N	N	7	1	13	77	93
Kansas	—	157	269	5,157	4,883	N	0	0	N	N	2	1	7	48	26
Minnesota	—	231	344	7,044	8,363	—	0	12	—	3	4	2	22	115	74
Missouri	—	434	563	13,986	15,229	—	0	0	—	1	—	2	21	64	191
Nebraska§	71	92	176	3,417	3,469	N	0	1	N	N	14	1	8	51	13
North Dakota	20	33	58	1,063	1,089	N	0	0	N	N	—	0	4	6	—
South Dakota	51	52	117	1,773	1,869	N	0	0	N	N	—	1	4	33	19
S. Atlantic	2,495	3,393	4,924	119,838	120,265	—	0	1	3	1	26	14	54	474	366
Delaware	62	70	92	2,392	2,206	N	0	0	N	N	—	0	3	6	3
District of Columbia	18	55	103	1,654	2,539	—	0	0	—	—	—	0	3	11	7
Florida	749	925	1,102	32,328	29,235	N	0	0	N	N	23	6	28	221	160
Georgia	18	624	2,142	19,059	21,082	—	0	0	—	—	—	3	9	116	87
Maryland§	304	341	486	11,833	12,481	—	0	1	3	1	—	0	4	11	19
North Carolina	730	562	1,772	22,782	22,492	N	0	0	N	N	—	1	10	53	39
South Carolina§	—	286	1,306	11,747	12,444	N	0	0	N	N	3	0	4	28	11
Virginia§	568	425	840	15,848	16,008	N	0	0	N	N	—	1	8	24	33
West Virginia	46	59	226	2,195	1,778	N	0	0	N	N	—	0	3	4	7
E.S. Central	538	1,412	1,942	49,176	47,051	—	0	0	—	—	6	3	29	95	88
Alabama§	—	380	755	13,554	10,389	N	0	0	N	N	6	0	5	37	17
Kentucky	—	155	402	6,108	6,387	N	0	0	N	N	—	1	25	25	46
Mississippi	—	380	801	12,529	14,623	—	0	0	—	—	—	0	1	8	—
Tennessee§	538	495	602	16,985	15,652	N	0	0	N	N	—	1	5	25	25
W.S. Central	912	2,101	3,605	71,041	76,227	—	0	1	—	—	2	3	24	95	128
Arkansas	170	162	340	5,204	5,687	—	0	0	—	—	1	0	2	14	3
Louisiana	11	254	761	9,637	12,910	—	0	1	—	N	—	0	14	8	49
Oklahoma	—	226	2,159	7,394	7,561	N	0	0	N	N	1	1	2	24	33
Texas§	731	1,389	1,775	48,806	50,069	N	0	0	N	N	—	2	19	49	43
Mountain	389	1,030	1,839	31,798	42,715	—	114	452	3,954	1,751	29	2	33	169	95
Arizona	377	365	642	12,273	14,617	—	111	448	3,888	1,682	—	0	2	15	9
Colorado	—	172	482	4,010	10,263	N	0	0	N	N	—	1	6	26	29
Idaho§	—	51	159	1,773	1,788	N	0	0	N	N	1	0	2	11	11
Montana	12	44	195	1,664	1,532	N	0	0	N	N	25	0	26	74	13
Nevada§	—	62	432	2,298	4,908	—	1	4	21	44	—	0	1	3	11
New Mexico§	—	160	338	5,833	5,884	—	0	2	8	13	—	0	3	7	9
Utah	—	93	136	3,049	2,980	—	1	3	35	10	—	0	3	8	11
Wyoming	—	27	55	898	743	—	0	2	2	2	3	0	11	25	2
Pacific	1,875	3,235	5,079	111,623	112,048	21	40	1,179	1,636	979	1	2	52	50	233
Alaska	49	85	152	2,819	2,796	—	0	0	—	—	—	0	2	4	—
California	1,320	2,559	4,231	87,668	87,173	21	40	1,179	1,636	979	—	0	14	—	135
Hawaii	—	104	135	3,337	3,663	N	0	0	N	N	—	0	1	3	1
Oregon§	255	174	315	5,905	5,889	N	0	0	N	N	1	1	6	43	56
Washington	251	350	604	11,894	12,527	N	0	0	N	N	—	0	38	—	41
American Samoa	U	0	46	U	U	U	0	0	U	U	U	0	0	U	U
C.N.M.I.	U	0	0	U	U	U	0	0	U	U	U	0	0	U	U
Guam	—	17	37	—	548	—	0	0	—	—	—	0	0	—	—
Puerto Rico	—	79	161	2,945	2,817	N	0	0	N	N	N	0	0	N	N
U.S. Virgin Islands	—	5	16	178	189	—	0	0	—	—	—	0	0	—	—

C.N.M.I.: Commonwealth of Northern Mariana Islands.
U: Unavailable. —: No reported cases. N: Not notifiable. Cum: Cumulative year-to-date counts. Med: Median. Max: Maximum.
* Incidence data for reporting years 2005 and 2006 are provisional.
† Chlamydia refers to genital infections caused by *Chlamydia trachomatis*.
§ Contains data reported through the National Electronic Disease Surveillance System (NEDSS).

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending September 2, 2006, and September 3, 2005 (35th Week)*

Reporting area	Giardiasis					Gonorrhea					*Haemophilus influenzae*, invasive All ages, all serotypes				
	Current week	Previous 52 weeks		Cum 2006	Cum 2005	Current week	Previous 52 weeks		Cum 2006	Cum 2005	Current week	Previous 52 weeks		Cum 2006	Cum 2005
		Med	Max				Med	Max				Med	Max		
United States	283	316	1,029	10,039	12,002	3,183	6,484	14,136	213,330	219,771	14	38	142	1,374	1,595
New England	39	24	75	806	1,077	95	101	288	3,570	4,007	3	3	19	119	120
Connecticut	24	0	37	184	230	—	40	241	1,323	1,755	2	0	9	36	37
Maine†	11	2	13	102	135	4	2	6	86	92	—	0	4	16	8
Massachusetts	—	10	34	339	482	74	46	86	1,657	1,711	1	1	7	51	58
New Hampshire	—	0	3	13	43	3	4	9	136	107	—	0	1	4	6
Rhode Island	—	0	25	67	70	14	8	19	323	304	—	0	7	4	7
Vermont†	4	3	9	101	117	—	1	4	45	38	—	0	2	8	4
Mid. Atlantic	48	53	254	1,760	2,134	255	611	1,014	19,648	22,360	4	7	30	264	300
New Jersey	—	7	17	206	287	23	104	150	3,102	3,818	—	2	4	45	57
New York (Upstate)	38	24	227	744	708	112	125	455	4,078	4,369	2	2	27	96	84
New York City	—	11	32	340	587	—	161	402	5,217	6,810	—	0	4	18	56
Pennsylvania	10	15	29	470	552	120	210	393	7,251	7,363	2	3	8	105	103
E.N. Central	17	48	110	1,486	2,150	558	1,278	7,047	41,746	43,269	1	5	14	195	284
Illinois	—	10	25	265	519	137	375	708	12,914	13,238	—	1	6	46	94
Indiana	N	0	0	N	N	157	163	236	5,850	5,399	1	1	7	51	52
Michigan	1	12	27	405	530	198	235	5,880	8,512	6,831	—	0	3	17	16
Ohio	16	16	34	505	480	22	351	661	10,202	13,992	—	1	6	58	90
Wisconsin	—	10	40	311	621	44	129	172	4,268	3,809	—	0	4	23	32
W.N. Central	70	29	260	1,198	1,317	64	361	436	11,778	12,558	2	2	15	91	77
Iowa	2	5	14	172	179	30	32	54	1,124	1,067	—	0	1	1	—
Kansas	4	4	9	126	130	—	47	124	1,422	1,748	1	0	3	13	8
Minnesota	60	2	238	476	557	—	62	105	1,808	2,319	1	0	9	47	33
Missouri	—	9	32	299	288	—	188	251	6,225	6,321	—	0	6	21	25
Nebraska†	3	2	8	71	78	27	22	56	875	794	—	0	2	5	10
North Dakota	1	0	7	10	8	2	2	7	66	60	—	0	3	4	1
South Dakota	—	1	7	44	77	5	6	13	258	249	—	0	0	—	—
S. Atlantic	34	49	95	1,511	1,785	1,106	1,487	2,334	52,333	51,737	4	10	26	369	380
Delaware	—	1	4	25	38	27	26	44	986	549	—	0	1	1	—
District of Columbia	2	1	5	47	35	25	35	66	1,077	1,372	—	0	1	3	6
Florida	28	18	39	676	625	392	433	548	15,372	13,225	2	3	9	123	92
Georgia	—	11	26	298	481	17	294	1,014	8,829	9,757	1	2	12	68	81
Maryland†	3	4	10	128	130	116	128	186	4,463	4,617	1	1	5	45	49
North Carolina	N	0	0	N	N	311	283	766	11,392	10,569	—	0	9	44	63
South Carolina†	—	1	7	59	77	—	125	748	5,306	5,559	—	1	3	25	24
Virginia†	1	8	50	261	370	203	130	288	4,288	5,627	—	1	8	45	43
West Virginia	—	0	5	17	29	15	17	42	620	462	—	0	4	15	22
E.S. Central	6	8	35	274	269	232	561	852	19,853	18,357	—	2	7	71	88
Alabama†	4	4	24	135	117	—	181	309	6,296	5,978	—	0	5	16	17
Kentucky	N	0	0	N	N	1	55	132	2,172	2,105	—	0	1	3	10
Mississippi	—	0	0	—	—	—	141	435	4,861	4,684	—	0	1	3	—
Tennessee†	2	4	12	139	152	231	188	279	6,524	5,590	—	1	4	49	61
W.S. Central	10	6	31	161	196	359	843	1,430	30,557	31,037	—	1	15	45	92
Arkansas	3	2	6	71	54	52	79	186	2,644	2,902	—	0	2	7	7
Louisiana	—	0	4	11	38	10	158	354	5,904	7,141	—	0	2	2	32
Oklahoma	7	2	24	79	104	—	80	764	2,759	3,065	—	1	14	34	49
Texas†	N	0	0	N	N	297	541	728	19,250	17,929	—	0	2	2	4
Mountain	9	27	54	898	933	106	215	552	6,903	9,217	—	4	8	140	162
Arizona	—	3	36	92	94	106	86	201	2,986	3,328	—	1	7	67	82
Colorado	—	8	33	275	329	—	40	90	1,196	2,180	—	1	4	37	35
Idaho†	4	3	11	112	94	—	2	10	100	75	—	0	1	3	4
Montana	4	2	11	63	40	—	3	20	136	94	—	0	0	—	—
Nevada†	—	1	6	37	71	—	22	194	783	1,960	—	0	1	—	13
New Mexico†	—	1	6	35	52	—	29	64	1,092	1,080	—	0	4	17	17
Utah	—	7	19	263	237	—	17	24	531	451	—	0	4	14	7
Wyoming	1	1	3	21	16	—	2	6	79	49	—	0	2	2	4
Pacific	50	59	202	1,945	2,141	408	807	961	26,942	27,229	—	2	20	80	92
Alaska	2	1	6	38	71	13	11	23	377	388	—	0	19	8	5
California	43	43	105	1,414	1,522	295	653	828	22,188	22,669	—	0	9	18	43
Hawaii	—	1	3	34	45	—	19	32	600	692	—	0	1	13	8
Oregon†	5	7	16	255	278	35	28	58	898	1,034	—	1	6	39	36
Washington	—	6	90	204	225	65	74	142	2,879	2,446	—	0	4	2	—
American Samoa	U	0	0	U	U	U	0	2	U	U	U	0	0	U	U
C.N.M.I.	U	0	0	U	U	U	0	0	U	U	U	0	0	U	U
Guam	—	0	0	—	11	—	1	15	—	70	—	0	2	—	5
Puerto Rico	—	2	20	32	167	—	6	16	188	260	—	0	1	—	3
U.S. Virgin Islands	—	0	0	—	—	—	0	5	30	45	—	0	0	—	—

C.N.M.I.: Commonwealth of Northern Mariana Islands.
U: Unavailable. —: No reported cases. N: Not notifiable. Cum: Cumulative year-to-date counts. Med: Median. Max: Maximum.
* Incidence data for reporting years 2005 and 2006 are provisional.
† Contains data reported through the National Electronic Disease Surveillance System (NEDSS).

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending September 2, 2006, and September 3, 2005 (35th Week)*

Reporting area	Hepatitis (viral, acute), by type: A — Current week	A — Previous 52 weeks Med	A — Previous 52 weeks Max	A — Cum 2006	A — Cum 2005	B — Current week	B — Previous 52 weeks Med	B — Previous 52 weeks Max	B — Cum 2006	B — Cum 2005	Legionellosis — Current week	Legionellosis — Previous 52 weeks Med	Legionellosis — Previous 52 weeks Max	Legionellosis — Cum 2006	Legionellosis — Cum 2005
United States	53	73	245	2,134	2,637	32	83	597	2,552	3,506	33	43	127	1,310	1,245
New England	2	4	22	117	314	1	1	9	46	99	—	2	12	67	80
Connecticut	2	1	3	29	36	—	0	3	—	34	—	0	8	19	22
Maine†	—	0	2	6	1	—	0	2	13	10	—	0	2	6	3
Massachusetts	—	2	13	50	192	—	0	5	14	32	—	1	6	26	33
New Hampshire	—	0	3	17	70	1	0	2	11	19	—	0	1	1	6
Rhode Island	—	0	4	8	10	—	0	4	8	1	—	0	10	12	12
Vermont†	—	0	2	7	5	—	0	1	—	3	—	0	3	3	4
Mid. Atlantic	6	7	24	208	431	—	8	55	265	459	14	12	43	437	424
New Jersey	—	2	9	54	84	—	2	10	72	175	—	1	10	57	77
New York (Upstate)	5	1	14	57	66	—	1	43	47	36	8	5	29	172	107
New York City	—	2	10	57	206	—	1	5	41	96	—	1	9	33	69
Pennsylvania	1	1	5	40	75	—	3	9	105	152	6	5	17	175	171
E.N. Central	4	6	15	167	234	2	7	24	238	394	10	8	25	270	229
Illinois	—	1	11	34	79	—	0	6	14	112	—	1	4	21	39
Indiana	1	0	5	19	12	—	0	17	35	28	—	0	6	19	14
Michigan	1	2	8	59	78	2	3	7	95	125	1	2	6	68	71
Ohio	2	1	4	41	35	—	2	10	88	96	9	4	19	143	83
Wisconsin	—	0	5	14	30	—	0	4	6	33	—	0	5	19	22
W.N. Central	1	2	30	87	64	3	4	22	104	180	—	1	14	47	51
Iowa	—	0	2	8	18	—	0	3	9	18	—	0	3	8	3
Kansas	—	0	5	22	12	1	0	2	8	22	—	0	2	4	2
Minnesota	—	0	29	9	3	1	0	13	14	20	—	0	11	11	11
Missouri	—	1	3	29	25	—	2	7	64	95	—	0	3	15	21
Nebraska†	1	0	3	12	6	1	0	1	9	20	—	0	2	5	2
North Dakota	—	0	2	—	—	—	0	0	—	—	—	0	1	—	2
South Dakota	—	0	3	7	—	—	0	1	—	5	—	0	6	4	10
S. Atlantic	11	11	34	351	447	19	23	66	774	965	5	8	19	265	262
Delaware	—	0	2	10	5	—	1	4	30	21	—	0	2	8	13
District of Columbia	—	0	2	5	2	—	0	2	5	10	—	0	5	14	8
Florida	8	4	18	139	165	14	8	19	284	332	3	3	9	111	68
Georgia	2	1	7	48	93	2	3	7	115	152	1	0	4	11	22
Maryland†	1	1	6	38	45	1	3	10	108	104	—	1	5	48	79
North Carolina	—	0	20	61	57	—	0	23	106	105	—	0	5	23	19
South Carolina†	—	0	3	12	24	1	2	7	47	109	—	0	1	2	11
Virginia†	—	1	11	34	53	1	1	18	36	105	1	1	7	41	32
West Virginia	—	0	3	4	3	—	0	18	43	27	—	0	3	7	10
E.S. Central	1	2	15	82	175	1	6	18	211	250	1	1	9	55	55
Alabama†	—	0	9	8	20	—	1	7	65	58	—	0	2	7	10
Kentucky	—	0	5	27	17	—	1	5	46	47	—	0	4	17	17
Mississippi	—	0	1	5	14	—	0	3	10	39	—	0	1	1	3
Tennessee†	1	1	6	42	124	1	2	12	90	106	1	1	7	30	25
W.S. Central	—	5	77	120	290	1	13	315	410	381	—	1	32	38	26
Arkansas	—	0	9	32	10	—	1	4	31	47	—	0	3	3	5
Louisiana	—	0	3	2	48	—	0	3	11	55	—	0	2	4	1
Oklahoma	—	0	2	4	4	1	0	17	26	30	—	0	3	1	3
Texas†	—	4	73	82	228	—	11	295	342	249	—	0	26	30	17
Mountain	—	5	18	174	207	—	5	39	136	362	2	2	7	66	69
Arizona	—	2	16	98	106	—	2	23	54	232	—	1	3	24	15
Colorado	—	1	4	26	26	—	1	5	24	39	—	0	2	7	17
Idaho†	—	0	2	8	18	—	0	2	10	7	1	0	2	7	3
Montana	—	0	3	9	7	—	0	7	—	3	1	0	1	5	5
Nevada†	—	0	2	7	14	—	0	4	14	37	—	0	2	3	13
New Mexico†	—	0	3	12	18	—	0	3	11	13	—	0	1	4	2
Utah	—	0	2	11	17	—	0	5	23	29	—	0	1	16	10
Wyoming	—	0	1	3	1	—	0	1	—	2	—	0	1	—	4
Pacific	28	20	163	828	475	5	10	61	368	416	1	2	9	65	49
Alaska	—	0	1	—	3	—	0	1	3	7	—	0	1	—	—
California	28	16	162	754	395	5	7	41	285	279	1	2	9	65	47
Hawaii	—	0	2	8	19	—	0	1	4	6	—	0	1	—	2
Oregon†	—	1	5	34	28	—	1	6	45	73	N	0	0	N	N
Washington	—	1	13	32	30	—	0	18	31	51	—	0	0	—	—
American Samoa	U	0	0	U	1	U	0	0	U	—	U	0	0	U	U
C.N.M.I.	U	0	0	U	U	U	0	0	U	U	U	0	0	U	U
Guam	—	0	0	—	2	—	0	0	—	18	—	0	0	—	—
Puerto Rico	—	0	3	16	54	1	1	8	22	33	—	0	1	1	—
U.S. Virgin Islands	—	0	0	—	—	—	0	0	—	—	—	0	0	—	—

C.N.M.I.: Commonwealth of Northern Mariana Islands.
U: Unavailable. —: No reported cases. N: Not notifiable. Cum: Cumulative year-to-date counts. Med: Median. Max: Maximum.
* Incidence data for reporting years 2005 and 2006 are provisional.
† Contains data reported through the National Electronic Disease Surveillance System (NEDSS).

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending September 2, 2006, and September 3, 2005 (35th Week)*

Reporting area	Lyme disease					Malaria				
	Current week	Previous 52 weeks		Cum 2006	Cum 2005	Current week	Previous 52 weeks		Cum 2006	Cum 2005
		Med	Max				Med	Max		
United States	253	248	2,153	10,352	15,431	12	24	125	778	930
New England	50	37	780	1,824	2,733	—	1	11	40	47
Connecticut	18	8	753	1,336	382	—	0	5	10	10
Maine†	23	2	8	77	197	—	0	1	3	4
Massachusetts	—	2	54	33	1,949	—	0	3	18	26
New Hampshire	4	5	45	325	149	—	0	3	8	4
Rhode Island	—	0	5	—	25	—	0	8	—	2
Vermont†	5	1	8	53	31	—	0	1	1	1
Mid. Atlantic	158	152	1,176	5,945	8,961	2	4	13	123	255
New Jersey	—	23	123	1,101	2,925	—	1	3	28	64
New York (Upstate)	139	78	1,150	2,647	2,404	2	1	11	23	31
New York City	—	1	15	10	301	—	2	8	46	134
Pennsylvania	19	40	212	2,187	3,331	—	1	3	26	26
E.N. Central	3	11	96	837	1,485	1	2	7	77	108
Illinois	—	0	3	—	115	—	1	5	28	61
Indiana	1	0	3	14	23	—	0	3	8	3
Michigan	2	1	6	34	38	—	0	2	13	18
Ohio	—	1	5	31	38	1	0	3	21	16
Wisconsin	—	10	91	758	1,271	—	0	3	7	10
W.N. Central	1	9	91	312	472	1	0	32	31	34
Iowa	—	1	8	61	76	—	0	1	1	5
Kansas	—	0	2	3	3	—	0	2	5	4
Minnesota	—	6	88	231	381	—	0	30	14	11
Missouri	—	0	3	8	10	—	0	2	5	13
Nebraska†	1	0	2	8	—	1	0	2	4	1
North Dakota	—	0	3	—	—	—	0	1	1	—
South Dakota	—	0	1	1	2	—	0	1	1	—
S. Atlantic	26	30	100	1,173	1,615	3	7	15	230	202
Delaware	—	8	27	347	525	—	0	1	5	3
District of Columbia	2	0	7	33	8	—	0	2	3	8
Florida	1	1	5	29	25	—	1	6	41	34
Georgia	1	0	1	2	5	2	1	6	63	40
Maryland†	14	16	56	559	846	—	1	5	50	71
North Carolina	—	0	5	21	35	1	0	8	19	21
South Carolina†	—	0	3	7	12	—	0	2	7	6
Virginia†	8	3	25	168	152	—	1	9	40	18
West Virginia	—	0	44	7	7	—	0	2	2	1
E.S. Central	2	0	4	14	23	—	0	3	19	20
Alabama†	—	0	1	5	—	—	0	2	8	4
Kentucky	2	0	2	4	3	—	0	2	3	5
Mississippi	—	0	0	—	—	—	0	1	3	—
Tennessee†	—	0	4	5	20	—	0	2	5	11
W.S. Central	—	0	3	10	62	—	2	31	51	77
Arkansas	—	0	1	—	4	—	0	1	1	5
Louisiana	—	0	0	—	3	—	0	1	1	2
Oklahoma	—	0	0	—	—	—	0	6	7	3
Texas†	—	0	3	10	55	—	1	29	42	67
Mountain	—	0	4	14	15	—	1	9	41	37
Arizona	—	0	4	3	3	—	0	9	15	6
Colorado	—	0	1	2	—	—	0	2	9	20
Idaho†	—	0	1	2	2	—	0	0	—	—
Montana	—	0	0	—	—	—	0	1	2	—
Nevada†	—	0	1	1	3	—	0	1	1	2
New Mexico†	—	0	1	1	2	—	0	1	1	3
Utah	—	0	1	5	2	—	0	2	13	5
Wyoming	—	0	0	—	3	—	0	1	—	1
Pacific	13	4	22	223	65	5	4	13	166	150
Alaska	—	0	1	2	4	—	0	4	21	3
California	13	4	21	211	40	5	3	10	115	111
Hawaii	N	0	0	N	N	—	0	2	4	14
Oregon†	—	0	2	7	17	—	0	2	8	9
Washington	—	0	3	3	4	—	0	5	18	13
American Samoa	U	0	0	U	U	U	0	0	U	U
C.N.M.I.	U	0	0	U	U	U	0	0	U	U
Guam	—	0	0	—	—	—	0	0	—	—
Puerto Rico	N	0	0	N	N	—	0	1	—	3
U.S. Virgin Islands	—	0	0	—	—	—	0	0	—	—

C.N.M.I.: Commonwealth of Northern Mariana Islands.
U: Unavailable. —: No reported cases. N: Not notifiable. Cum: Cumulative year-to-date counts. Med: Median. Max: Maximum.
* Incidence data for reporting years 2005 and 2006 are provisional.
† Contains data reported through the National Electronic Disease Surveillance System (NEDSS).

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending September 2, 2006, and September 3, 2005 (35th Week)*

Reporting area	Meningococcal disease, invasive: All serogroups: Current week	Previous 52 weeks: Med	Previous 52 weeks: Max	Cum 2006	Cum 2005	Meningococcal disease, invasive: Serogroup unknown: Current week	Previous 52 weeks: Med	Previous 52 weeks: Max	Cum 2006	Cum 2005	Pertussis: Current week	Previous 52 weeks: Med	Previous 52 weeks: Max	Cum 2006	Cum 2005
United States	8	20	85	770	894	7	13	58	512	545	101	277	2,877	8,544	14,891
New England	—	1	3	34	58	—	0	2	24	20	2	29	83	850	890
Connecticut	—	0	2	9	12	—	0	2	2	1	—	1	5	32	48
Maine†	—	0	1	4	2	—	0	1	3	2	1	1	7	38	30
Massachusetts	—	0	2	14	27	—	0	2	14	5	1	22	43	587	675
New Hampshire	—	0	2	5	10	—	0	2	5	10	—	2	36	107	45
Rhode Island	—	0	1	—	2	—	0	0	—	—	—	0	17	—	21
Vermont†	—	0	1	2	5	—	0	0	—	2	—	1	14	86	71
Mid. Atlantic	1	3	14	116	109	—	2	11	87	84	31	32	137	1,163	909
New Jersey	—	0	2	11	26	—	0	2	11	26	—	4	13	140	128
New York (Upstate)	1	1	7	30	30	—	0	5	5	11	23	13	123	505	341
New York City	—	1	6	39	17	—	1	6	39	17	—	1	8	52	73
Pennsylvania	—	1	5	36	36	—	1	5	32	30	8	11	26	466	367
E.N. Central	2	3	11	88	113	2	2	6	64	93	16	44	133	1,234	2,528
Illinois	—	0	4	18	26	—	0	4	18	26	—	10	35	227	589
Indiana	1	0	5	18	16	1	0	2	9	7	3	5	75	153	202
Michigan	—	0	3	17	23	—	0	3	8	14	4	7	23	319	181
Ohio	1	1	5	32	29	1	1	4	26	27	9	14	30	403	810
Wisconsin	—	0	2	3	19	—	0	2	3	19	—	6	41	132	746
W.N. Central	—	1	4	43	59	—	0	3	14	26	14	33	552	820	2,367
Iowa	—	0	2	12	14	—	0	1	4	1	1	7	63	180	523
Kansas	—	0	1	1	9	—	0	1	1	9	5	8	28	205	235
Minnesota	—	0	2	10	9	—	0	1	3	3	—	0	485	137	868
Missouri	—	0	2	13	20	—	0	1	2	10	—	7	42	184	312
Nebraska†	—	0	2	5	4	—	0	1	3	3	2	3	10	71	202
North Dakota	—	0	1	1	—	—	0	1	1	—	6	0	26	26	77
South Dakota	—	0	1	1	3	—	0	0	—	—	—	1	7	17	150
S. Atlantic	—	3	14	131	164	—	2	7	53	65	25	22	46	659	986
Delaware	—	0	1	4	3	—	0	1	4	3	—	0	1	3	14
District of Columbia	—	0	1	1	5	—	0	1	1	4	—	0	3	3	7
Florida	—	1	6	50	61	—	0	5	19	20	2	4	14	143	128
Georgia	—	0	3	10	14	—	0	3	10	14	—	0	3	11	37
Maryland†	—	0	2	8	15	—	0	1	1	1	3	3	9	86	148
North Carolina	—	0	11	23	27	—	0	3	7	5	—	0	22	141	64
South Carolina†	—	0	2	15	13	—	0	1	5	8	5	4	22	103	287
Virginia†	—	0	4	15	21	—	0	3	6	8	15	2	27	146	264
West Virginia	—	0	2	5	5	—	0	0	—	2	—	0	9	23	37
E.S. Central	1	1	4	28	44	1	0	4	22	34	10	6	14	216	394
Alabama†	1	0	1	5	4	1	0	1	4	3	6	1	4	47	61
Kentucky	—	0	2	7	15	—	0	2	7	15	—	1	5	41	116
Mississippi	—	0	1	1	5	—	0	1	1	5	—	0	4	23	45
Tennessee†	—	0	2	15	20	—	0	2	10	11	4	2	10	105	172
W.S. Central	1	1	23	47	87	1	0	6	20	21	—	18	360	400	1,599
Arkansas	—	0	3	9	11	—	0	2	6	3	—	2	21	41	223
Louisiana	—	0	1	2	27	—	0	1	1	4	—	0	3	5	42
Oklahoma	—	0	4	8	13	—	0	0	—	2	—	0	124	18	1
Texas†	1	1	16	28	36	1	0	4	13	12	—	18	215	336	1,333
Mountain	—	1	5	49	72	—	0	4	26	20	2	64	230	1,894	2,862
Arizona	—	0	3	15	30	—	0	3	15	10	—	11	177	376	726
Colorado	—	0	2	15	15	—	0	1	3	—	—	22	40	573	904
Idaho†	—	0	2	3	4	—	0	2	2	3	1	2	13	58	155
Montana	—	0	1	3	—	—	0	1	1	—	—	2	14	87	516
Nevada†	—	0	2	2	9	—	0	0	—	2	—	0	9	39	40
New Mexico†	—	0	1	2	4	—	0	1	—	3	—	2	6	54	141
Utah	—	0	1	5	10	—	0	1	1	2	—	15	39	650	346
Wyoming	—	0	2	4	—	—	0	2	4	—	1	1	8	57	34
Pacific	3	5	29	234	188	3	5	25	202	182	1	47	1,334	1,308	2,356
Alaska	—	0	1	2	1	—	0	1	2	1	—	2	15	50	73
California	3	3	14	145	123	3	3	14	145	123	1	29	1,136	889	1,010
Hawaii	—	0	1	6	10	—	0	1	6	5	—	2	6	51	124
Oregon†	—	1	7	54	35	—	1	4	38	35	—	3	9	84	574
Washington	—	0	25	27	19	—	0	11	11	18	—	7	195	234	575
American Samoa	U	0	0	—	—	U	0	0	U	U	U	0	0	U	U
C.N.M.I.	U	0	0	—	—	U	0	0	U	U	U	0	0	U	U
Guam	—	0	0	—	1	—	0	0	—	1	—	0	0	—	2
Puerto Rico	—	0	1	4	6	—	0	1	4	6	—	0	1	1	5
U.S. Virgin Islands	—	0	0	—	—	—	0	0	—	—	—	0	0	—	—

C.N.M.I.: Commonwealth of Northern Mariana Islands.
U: Unavailable. —: No reported cases. N: Not notifiable. Cum: Cumulative year-to-date counts. Med: Median. Max: Maximum.
* Incidence data for reporting years 2005 and 2006 are provisional.
† Contains data reported through the National Electronic Disease Surveillance System (NEDSS).

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending September 2, 2006, and September 3, 2005 (35th Week)*

Reporting area	Rabies, animal					Rocky Mountain spotted fever					Salmonellosis				
	Current week	Previous 52 weeks		Cum 2006	Cum 2005	Current week	Previous 52 weeks		Cum 2006	Cum 2005	Current week	Previous 52 weeks		Cum 2006	Cum 2005
		Med	Max				Med	Max				Med	Max		
United States	65	111	166	3,903	4,183	44	35	246	1,214	1,098	638	809	2,291	24,127	27,267
New England	21	12	25	439	508	—	0	2	2	5	11	33	306	1,334	1,517
Connecticut	8	3	14	124	129	—	0	0	—	—	—	0	298	298	312
Maine†	3	1	5	67	46	N	0	0	N	N	2	2	10	80	120
Massachusetts	4	4	17	174	266	—	0	2	1	3	2	19	53	743	809
New Hampshire	2	0	5	31	10	—	0	1	1	1	4	2	23	120	130
Rhode Island	—	0	4	1	15	—	0	2	—	1	2	0	17	57	72
Vermont†	4	1	4	42	42	—	0	0	—	—	1	1	4	36	74
Mid. Atlantic	—	21	50	784	657	1	1	6	32	68	57	84	272	2,845	3,395
New Jersey	N	0	0	N	N	—	0	2	4	21	1	15	41	563	673
New York (Upstate)	—	11	20	369	358	—	0	1	2	1	37	22	233	754	781
New York City	—	0	3	—	20	—	0	1	4	6	—	17	44	505	794
Pennsylvania	—	9	35	415	279	1	1	3	22	40	19	28	65	1,023	1,147
E.N. Central	8	2	17	121	143	—	0	4	24	36	105	101	189	3,264	3,943
Illinois	1	0	6	34	36	—	0	1	1	11	—	26	48	746	1,344
Indiana	1	0	3	9	10	—	0	1	5	—	56	12	67	558	376
Michigan	1	1	5	38	27	—	0	1	2	5	5	17	32	609	652
Ohio	5	0	9	40	70	—	0	4	15	18	44	23	56	824	899
Wisconsin	N	0	0	N	N	—	0	1	1	2	—	15	42	527	672
W.N. Central	4	5	20	213	251	1	2	11	121	121	29	42	107	1,581	1,688
Iowa	3	0	7	47	—	—	0	2	2	3	—	7	18	268	277
Kansas	—	1	5	58	64	—	0	1	1	5	5	7	13	223	252
Minnesota	1	1	6	34	52	—	0	1	2	2	16	10	60	441	367
Missouri	—	1	6	38	55	—	2	10	99	101	—	13	40	441	514
Nebraska†	—	0	0	—	—	1	0	4	17	5	7	3	12	121	137
North Dakota	—	0	7	15	25	—	0	1	—	—	1	0	46	17	22
South Dakota	—	0	4	21	55	—	0	0	—	5	—	2	7	70	119
S. Atlantic	19	36	118	1,381	1,524	33	18	94	738	566	205	204	514	6,265	7,175
Delaware	—	0	0	—	—	—	0	3	17	5	—	2	9	87	81
District of Columbia	—	0	0	—	—	—	0	1	1	2	—	1	7	39	38
Florida	—	0	99	116	201	1	0	3	14	12	139	95	230	2,793	2,684
Georgia	—	3	9	99	196	—	0	3	16	77	39	27	87	913	1,155
Maryland†	—	7	14	239	254	1	1	3	30	55	20	12	30	431	541
North Carolina	12	8	22	340	349	31	15	87	570	307	—	32	114	851	923
South Carolina†	—	3	10	105	156	—	1	6	19	45	5	18	73	492	906
Virginia†	7	10	27	412	332	—	2	13	68	58	1	20	62	595	743
West Virginia	—	1	13	70	36	—	0	2	3	5	1	3	19	64	104
E.S. Central	6	4	16	172	107	6	5	20	179	202	45	52	125	1,550	1,846
Alabama†	3	1	7	55	58	1	1	6	45	53	19	13	63	512	451
Kentucky	2	0	5	17	8	—	0	1	1	2	7	8	21	268	311
Mississippi	—	0	2	4	4	—	0	2	1	9	—	11	62	303	524
Tennessee†	1	2	9	96	37	5	3	16	132	138	19	14	36	467	560
W.S. Central	3	15	34	546	652	2	1	161	80	73	31	80	922	2,156	2,600
Arkansas	—	0	4	24	26	—	0	32	34	44	22	14	43	526	477
Louisiana	—	0	0	—	—	—	0	1	—	6	—	7	38	174	597
Oklahoma	3	1	9	51	61	2	0	154	35	7	9	7	48	287	256
Texas†	—	13	29	471	565	—	0	3	11	16	—	46	839	1,169	1,270
Mountain	—	3	16	115	195	1	0	6	31	25	7	50	84	1,543	1,587
Arizona	—	2	11	87	124	—	0	6	5	12	—	15	67	480	424
Colorado	—	0	1	—	16	—	0	1	2	4	—	12	30	404	408
Idaho†	—	0	12	—	—	1	0	3	8	3	3	3	9	120	108
Montana	—	0	2	11	10	—	0	2	2	1	4	2	16	93	62
Nevada†	—	0	1	—	11	—	0	0	—	—	—	3	17	69	121
New Mexico†	—	0	2	7	8	—	0	2	5	3	—	4	12	144	183
Utah	—	0	5	6	12	—	0	2	5	—	—	5	15	198	220
Wyoming	—	0	2	4	14	—	0	1	4	2	—	1	5	35	61
Pacific	4	4	10	132	146	—	0	1	7	2	148	109	426	3,589	3,516
Alaska	—	0	4	13	1	—	0	0	—	—	1	1	7	52	38
California	4	3	10	108	141	—	0	1	5	—	145	86	292	2,824	2,645
Hawaii	—	0	0	—	—	—	0	0	—	—	—	4	15	144	196
Oregon†	—	0	4	11	4	—	0	1	2	2	2	7	16	268	293
Washington	U	0	0	U	U	N	0	0	N	N	—	8	124	301	344
American Samoa	U	0	0	U	U	U	0	0	U	U	U	0	2	U	3
C.N.M.I.	U	0	0	U	U	U	0	0	U	U	U	0	0	U	U
Guam	—	0	0	—	—	—	0	0	—	—	—	1	3	—	29
Puerto Rico	3	1	6	63	50	N	0	0	N	N	8	5	35	126	427
U.S. Virgin Islands	—	0	0	—	—	—	0	0	—	—	—	0	0	—	—

C.N.M.I.: Commonwealth of Northern Mariana Islands.
U: Unavailable. —: No reported cases. N: Not notifiable. Cum: Cumulative year-to-date counts. Med: Median. Max: Maximum.
* Incidence data for reporting years 2005 and 2006 are provisional.
† Contains data reported through the National Electronic Disease Surveillance System (NEDSS).

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending September 2, 2006, and September 3, 2005 (35th Week)*

Reporting area	Shiga toxin-producing *E. coli* (STEC)†					Shigellosis					Streptococcal disease, invasive, group A				
	Current week	Previous 52 weeks		Cum 2006	Cum 2005	Current week	Previous 52 weeks		Cum 2006	Cum 2005	Current week	Previous 52 weeks		Cum 2006	Cum 2005
		Med	Max				Med	Max				Med	Max		
United States	50	54	297	1,608	1,816	163	220	1,013	6,686	9,185	36	87	283	3,518	3,335
New England	2	3	48	179	143	1	4	48	182	212	5	5	15	167	208
Connecticut	—	0	47	47	36	—	0	42	42	34	U	0	3	U	78
Maine§	1	0	8	23	25	—	0	3	3	12	—	0	2	15	12
Massachusetts	1	2	9	76	53	1	3	8	119	133	1	3	6	101	87
New Hampshire	—	0	3	17	13	—	0	4	7	6	4	0	9	37	14
Rhode Island	—	0	2	4	3	—	0	6	8	12	—	0	3	5	8
Vermont§	—	0	2	2	13	—	0	1	3	15	—	0	2	9	9
Mid. Atlantic	6	5	107	111	211	9	16	72	502	829	4	15	43	643	691
New Jersey	—	0	7	3	45	—	5	24	188	233	—	2	7	107	145
New York (Upstate)	—	0	103	12	74	5	4	60	166	190	3	4	32	238	196
New York City	—	0	4	13	9	—	4	12	94	298	—	1	10	69	136
Pennsylvania	—	0	7	3	83	4	2	48	54	108	1	6	13	229	214
E.N. Central	11	11	31	322	368	4	20	41	597	748	4	14	43	645	704
Illinois	—	1	7	53	101	—	7	25	199	231	—	4	11	144	231
Indiana	4	1	6	48	39	1	2	18	87	104	—	2	11	90	82
Michigan	1	1	6	55	63	—	3	10	108	169	—	3	12	172	168
Ohio	5	3	14	94	78	3	3	11	107	71	4	4	19	197	150
Wisconsin	1	2	11	72	87	—	3	9	96	173	—	1	4	42	73
W.N. Central	11	8	35	243	287	28	34	77	952	966	7	5	57	247	210
Iowa	—	2	8	85	65	—	2	10	62	58	N	0	0	N	N
Kansas	—	0	3	—	28	5	4	20	86	128	—	1	5	44	33
Minnesota	10	3	19	134	67	3	2	9	79	58	6	0	52	121	77
Missouri	—	2	13	110	68	—	13	69	474	628	—	1	5	47	54
Nebraska§	2	1	5	32	35	2	2	14	78	63	—	0	4	21	18
North Dakota	—	0	15	—	3	18	0	12	53	2	1	0	5	8	9
South Dakota	—	0	5	19	21	—	3	17	120	29	—	0	3	6	19
S. Atlantic	7	7	39	260	252	51	53	122	1,704	1,336	14	21	42	827	654
Delaware	—	0	3	8	5	—	0	2	7	10	—	0	2	8	5
District of Columbia	—	0	1	—	—	1	0	2	10	8	—	0	2	9	7
Florida	1	2	29	60	65	36	26	66	830	667	—	6	16	204	170
Georgia	2	1	6	57	33	5	16	38	561	325	6	4	11	157	135
Maryland§	2	1	5	37	46	2	2	10	80	56	6	4	12	151	128
North Carolina	4	1	10	65	37	6	1	22	109	111	—	1	26	126	91
South Carolina§	—	0	2	4	7	1	1	9	62	69	—	1	6	50	29
Virginia§	—	0	8	—	57	—	1	8	43	90	2	2	11	100	67
West Virginia	—	0	2	—	2	—	0	2	2	—	—	0	6	22	22
E.S. Central	4	2	14	118	105	7	13	31	399	925	2	3	11	152	133
Alabama§	—	0	5	18	21	1	3	14	121	180	N	0	0	N	N
Kentucky	—	1	8	38	39	1	5	12	156	216	—	0	5	32	26
Mississippi	—	0	1	—	5	—	1	6	37	60	—	0	0	—	—
Tennessee§	—	1	4	24	40	5	3	11	85	469	2	3	9	120	107
W.S. Central	1	1	52	20	63	10	26	596	606	2,394	—	7	58	274	231
Arkansas	1	0	2	10	9	3	1	7	63	43	—	0	5	23	14
Louisiana	—	0	1	—	18	2	0	7	31	108	—	0	1	1	5
Oklahoma	—	0	8	10	17	5	3	286	77	479	—	2	14	75	85
Texas§	—	1	44	51	19	—	22	308	435	1,764	—	4	43	175	127
Mountain	4	5	13	156	191	2	22	47	602	473	—	12	78	488	433
Arizona	—	1	8	58	20	—	11	29	341	240	—	6	57	260	179
Colorado	—	1	6	47	46	—	3	18	95	74	—	3	8	105	138
Idaho§	—	1	7	40	26	1	0	4	14	10	—	0	2	7	2
Montana	—	0	1	—	12	—	0	1	5	5	—	0	0	—	—
Nevada§	—	0	3	9	15	—	1	8	29	39	—	0	6	—	1
New Mexico§	—	0	2	4	19	—	2	10	74	72	—	1	7	58	66
Utah	—	1	10	57	46	—	1	4	41	31	—	1	7	55	44
Wyoming	3	0	3	13	7	1	0	1	3	2	—	0	1	3	3
Pacific	4	7	55	199	196	51	39	148	1,142	1,302	—	2	9	75	71
Alaska	—	0	1	—	9	—	0	2	8	11	—	0	0	—	—
California	4	4	18	130	83	51	32	104	939	1,098	—	0	0	—	—
Hawaii	—	0	2	10	9	—	1	4	29	25	—	2	9	75	71
Oregon§	1	2	47	54	55	—	1	31	89	96	N	0	0	N	N
Washington	—	2	32	59	40	—	2	43	77	72	N	0	0	N	N
American Samoa	U	0	0	U	U	U	0	2	U	5	U	0	0	U	U
C.N.M.I.	U	0	0	U	U	U	0	0	U	U	U	0	0	U	U
Guam	—	0	0	—	—	—	0	3	—	12	—	0	0	—	—
Puerto Rico	—	0	1	—	2	—	0	2	10	3	N	0	0	N	N
U.S. Virgin Islands	—	0	0	—	—	—	0	0	—	—	—	0	0	—	—

C.N.M.I.: Commonwealth of Northern Mariana Islands.
U: Unavailable. —: No reported cases. N: Not notifiable. Cum: Cumulative year-to-date counts. Med: Median. Max: Maximum.
* Incidence data for reporting years 2005 and 2006 are provisional.
† Includes *E. coli* O157:H7; Shiga toxin positive, serogroup non-0157; and Shiga toxin positive, not serogrouped.
§ Contains data reported through the National Electronic Disease Surveillance System (NEDSS).

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending September 2, 2006, and September 3, 2005 (35th Week)*

Reporting area	*Streptococcus pneumoniae*, invasive disease Drug resistant, all ages					Syphilis, primary and secondary					Varicella (chickenpox)				
	Current week	Previous 52 weeks Med	Previous 52 weeks Max	Cum 2006	Cum 2005	Current week	Previous 52 weeks Med	Previous 52 weeks Max	Cum 2006	Cum 2005	Current week	Previous 52 weeks Med	Previous 52 weeks Max	Cum 2006	Cum 2005
United States	15	51	334	1,764	1,863	68	170	334	5,698	5,629	127	800	3,204	28,914	19,155
New England	—	1	24	19	166	4	4	17	143	140	1	43	144	1,060	3,698
Connecticut	U	0	7	U	69	—	0	11	28	30	U	0	58	U	1,057
Maine†	N	0	0	N	N	—	0	2	7	1	—	5	20	151	219
Massachusetts	—	0	6	—	74	3	2	6	88	87	—	5	54	94	1,680
New Hampshire	—	0	0	—	—	1	0	2	11	11	—	5	47	316	205
Rhode Island	—	0	11	9	14	—	0	6	7	10	—	0	0	—	—
Vermont†	—	0	2	10	9	—	0	1	2	1	1	12	50	499	537
Mid. Atlantic	—	3	15	114	163	3	21	35	721	703	26	105	183	3,309	3,250
New Jersey	N	0	0	N	N	—	3	7	111	95	—	0	0	—	—
New York (Upstate)	—	1	10	41	64	—	2	14	96	51	—	0	0	—	—
New York City	U	0	0	U	U	—	10	23	340	436	—	0	0	—	—
Pennsylvania	—	2	9	73	99	3	5	9	174	121	26	105	183	3,309	3,250
E.N. Central	2	11	41	418	469	12	17	38	606	609	31	237	586	10,656	4,038
Illinois	—	0	3	15	22	2	8	23	289	341	—	1	6	38	68
Indiana	—	2	21	112	146	3	1	4	56	46	—	0	475	475	251
Michigan	—	0	4	17	30	2	2	19	81	56	6	102	174	3,074	2,418
Ohio	2	6	32	274	271	5	4	8	143	143	25	82	420	6,498	985
Wisconsin	N	0	0	N	N	—	1	4	37	23	—	12	52	571	316
W.N. Central	—	1	191	33	30	1	4	9	159	174	3	22	84	1,031	293
Iowa	N	0	0	N	N	—	0	3	10	6	N	0	0	N	N
Kansas	N	0	0	N	N	—	0	2	15	14	2	0	8	15	—
Minnesota	—	0	191	—	—	—	1	3	21	52	—	0	0	—	—
Missouri	—	1	3	32	24	—	3	8	103	98	—	17	82	945	202
Nebraska†	—	0	0	—	2	—	0	1	3	3	—	0	0	—	—
North Dakota	—	0	1	—	1	—	0	1	—	—	1	0	25	36	13
South Dakota	—	0	1	1	3	1	0	3	7	1	—	1	12	35	78
S. Atlantic	11	27	53	951	767	20	42	186	1,352	1,334	10	90	860	3,083	1,449
Delaware	—	0	2	—	1	—	0	2	16	8	—	1	5	45	22
District of Columbia	—	0	3	21	13	2	2	9	79	69	1	0	5	25	24
Florida	7	13	36	524	416	6	15	29	497	466	—	0	0	—	—
Georgia	4	8	29	315	245	1	7	147	200	254	—	0	0	—	—
Maryland†	—	0	0	—	—	3	5	19	197	217	—	0	0	—	—
North Carolina	N	0	0	N	N	4	6	17	204	185	—	0	0	—	—
South Carolina†	—	0	0	—	—	—	1	7	47	42	—	16	52	751	379
Virginia†	N	0	0	N	N	4	3	12	109	91	—	30	812	1,217	314
West Virginia	—	1	14	91	92	—	0	1	3	2	9	26	70	1,045	710
E.S. Central	2	3	13	141	129	6	12	24	455	310	2	0	70	87	36
Alabama†	N	0	0	N	N	—	4	18	192	103	2	0	70	86	36
Kentucky	—	0	5	27	24	3	1	8	48	30	N	0	0	N	N
Mississippi	—	0	0	—	1	—	0	6	42	37	—	0	1	1	—
Tennessee†	2	3	13	114	104	3	5	13	173	140	N	0	0	N	N
W.S. Central	—	0	4	14	99	16	26	45	997	841	51	185	1,757	7,833	4,554
Arkansas	—	0	3	11	12	2	1	6	48	32	1	7	110	585	—
Louisiana	—	0	4	3	87	7	4	17	152	192	—	0	8	43	108
Oklahoma	N	0	0	N	N	—	1	6	45	27	—	0	0	—	—
Texas†	N	0	0	N	N	7	21	39	752	590	50	167	1,647	7,205	4,446
Mountain	—	2	27	74	40	2	7	19	252	288	3	52	138	1,855	1,837
Arizona	N	0	0	N	N	2	4	16	129	101	—	0	0	—	—
Colorado	N	0	0	N	N	—	1	3	30	30	—	33	76	980	1,247
Idaho†	N	0	0	N	N	—	0	1	2	20	—	0	0	—	—
Montana	—	0	1	—	—	—	0	1	1	5	—	0	0	—	—
Nevada†	—	0	27	4	2	—	1	12	48	87	—	0	2	4	—
New Mexico†	—	0	1	1	—	—	1	5	37	38	3	3	34	295	162
Utah	—	0	8	32	17	—	0	1	5	7	—	10	55	544	379
Wyoming	—	1	3	37	21	—	0	0	—	—	—	0	8	32	49
Pacific	—	0	0	—	—	4	31	49	1,013	1,230	—	0	0	—	—
Alaska	—	0	0	—	—	—	0	4	5	6	—	0	0	—	—
California	N	0	0	N	N	1	28	39	853	1,099	—	0	0	—	—
Hawaii	—	0	0	—	—	—	0	2	12	8	N	0	0	N	N
Oregon†	N	0	0	N	N	1	0	6	13	21	N	0	0	N	N
Washington	N	0	0	N	N	2	2	11	130	96	N	0	0	N	N
American Samoa	—	0	0	—	—	U	0	0	U	U	U	0	0	U	U
C.N.M.I.	—	0	0	—	—	U	0	0	U	U	U	0	0	U	U
Guam	—	0	0	—	—	—	0	0	—	3	—	2	12	—	379
Puerto Rico	N	0	0	N	N	—	3	10	86	149	1	7	47	221	508
U.S. Virgin Islands	—	0	0	—	—	—	0	0	—	—	—	0	0	—	—

C.N.M.I.: Commonwealth of Northern Mariana Islands.
U: Unavailable. —: No reported cases. N: Not notifiable. Cum: Cumulative year-to-date counts. Med: Median. Max: Maximum.
* Incidence data for reporting years 2005 and 2006 are provisional.
† Contains data reported through the National Electronic Disease Surveillance System (NEDSS).

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending September 2, 2006, and September 3, 2005 (35th Week)*

Reporting area	West Nile virus disease†									
	Neuroinvasive					Non-neuroinvasive				
	Current week	Previous 52 weeks		Cum 2006	Cum 2005	Current week	Previous 52 weeks		Cum 2006	Cum 2005
		Med	Max				Med	Max		
United States	2	1	122	448	856	—	1	229	785	1,225
New England	—	0	3	4	4	—	0	2	2	—
Connecticut	—	0	2	4	2	—	0	1	2	—
Maine§	—	0	0	—	—	—	0	0	—	—
Massachusetts	—	0	3	—	1	—	0	1	—	—
New Hampshire	—	0	0	—	—	—	0	0	—	—
Rhode Island	—	0	1	—	1	—	0	0	—	—
Vermont§	—	0	0	—	—	—	0	0	—	—
Mid. Atlantic	—	0	8	5	23	—	0	4	2	15
New Jersey	—	0	1	—	—	—	0	2	1	—
New York (Upstate)	—	0	4	—	9	—	0	2	—	3
New York City	—	0	2	1	4	—	0	0	—	3
Pennsylvania	—	0	3	4	10	—	0	2	1	9
E.N. Central	—	0	37	39	171	—	0	17	9	87
Illinois	—	0	13	31	96	—	0	11	7	72
Indiana	—	0	2	1	7	—	0	1	—	—
Michigan	—	0	14	3	29	—	0	3	—	3
Ohio	—	0	8	2	35	—	0	4	1	9
Wisconsin	—	0	3	2	4	—	0	2	1	3
W.N. Central	—	0	22	92	113	—	0	48	192	365
Iowa	—	0	3	5	7	—	0	4	4	10
Kansas	—	0	3	12	7	—	0	2	6	N
Minnesota	—	0	5	17	11	—	0	7	25	18
Missouri	—	0	5	12	9	—	0	3	3	8
Nebraska§	—	0	6	14	36	—	0	17	41	99
North Dakota	—	0	4	10	12	—	0	19	67	65
South Dakota	—	0	7	22	31	—	0	17	46	165
S. Atlantic	—	0	6	5	16	—	0	3	—	15
Delaware	—	0	0	—	1	—	0	0	—	—
District of Columbia	—	0	1	—	—	—	0	1	—	—
Florida	—	0	2	2	7	—	0	0	—	11
Georgia	—	0	3	2	1	—	0	3	—	2
Maryland§	—	0	2	—	3	—	0	0	—	1
North Carolina	—	0	1	—	2	—	0	1	—	1
South Carolina§	—	0	1	—	2	—	0	0	—	—
Virginia§	—	0	0	—	—	—	0	1	—	—
West Virginia	—	0	1	1	—	N	0	0	N	N
E.S. Central	—	0	10	21	35	—	0	5	11	20
Alabama§	—	0	1	—	4	—	0	2	—	2
Kentucky	—	0	1	—	2	—	0	0	—	—
Mississippi	—	0	9	21	20	—	0	5	11	17
Tennessee§	—	0	3	—	9	—	0	1	—	1
W.S. Central	1	0	32	133	169	—	0	15	33	111
Arkansas	—	0	3	7	8	—	0	2	2	12
Louisiana	1	0	8	29	81	—	0	5	14	42
Oklahoma	—	0	6	12	3	—	0	3	1	2
Texas§	—	0	19	85	77	—	0	9	16	55
Mountain	1	0	30	114	75	—	0	142	423	159
Arizona	1	0	8	7	17	—	0	8	4	25
Colorado	—	0	5	18	10	—	0	18	57	63
Idaho§	—	0	7	26	3	—	0	100	260	9
Montana	—	0	2	3	8	—	0	3	7	16
Nevada§	—	0	9	27	7	—	0	10	49	13
New Mexico§	—	0	2	1	13	—	0	4	1	11
Utah	—	0	7	29	16	—	0	12	33	18
Wyoming	—	0	2	3	1	—	0	5	12	4
Pacific	—	0	29	35	250	—	0	44	113	453
Alaska	—	0	0	—	—	—	0	0	—	—
California	—	0	28	33	249	—	0	44	94	447
Hawaii	—	0	0	—	—	—	0	0	—	—
Oregon§	—	0	1	2	1	—	0	9	19	6
Washington	—	0	0	—	—	—	0	0	—	—
American Samoa	U	0	0	U	U	U	0	0	U	U
C.N.M.I.	U	0	0	U	U	U	0	0	U	U
Guam	—	0	0	—	—	—	0	0	—	—
Puerto Rico	—	0	0	—	—	—	0	0	—	—
U.S. Virgin Islands	—	0	0	—	—	—	0	0	—	—

C.N.M.I.: Commonwealth of Northern Mariana Islands.
U: Unavailable. —: No reported cases. N: Not notifiable. Cum: Cumulative year-to-date counts. Med: Median. Max: Maximum.
* Incidence data for reporting years 2005 and 2006 are provisional.
† Updated weekly from reports to the Division of Vector-Borne Infectious Diseases, National Center for Zoonotic, Vector-Borne, and Enteric Diseases (proposed) (ArboNET Surveillance).
§ Contains data reported through the National Electronic Disease Surveillance System (NEDSS).

TABLE III. Deaths in 122 U.S. cities,* week ending September 2, 2006 (35th Week)

Reporting Area	All causes, by age (years)						P&I† Total
	All Ages	≥65	45-64	25-44	1-24	<1	
New England	412	278	90	26	7	11	25
Boston, MA	122	86	20	6	3	7	14
Bridgeport, CT	33	21	6	6	—	—	3
Cambridge, MA	12	8	4	—	—	—	—
Fall River, MA	24	18	6	—	—	—	1
Hartford, CT	36	23	11	1	1	—	—
Lowell, MA	17	10	5	2	—	—	—
Lynn, MA	10	6	2	1	1	—	—
New Bedford, MA	11	8	2	1	—	—	1
New Haven, CT	U	U	U	U	U	U	U
Providence, RI	44	28	11	3	—	2	1
Somerville, MA	2	1	1	—	—	—	—
Springfield, MA	37	23	10	2	2	—	1
Waterbury, CT	15	10	3	2	—	—	2
Worcester, MA	49	36	9	2	—	2	2
Mid. Atlantic	1,888	1,276	411	125	30	42	87
Albany, NY	54	36	12	2	—	4	2
Allentown, PA	20	17	2	1	—	—	—
Buffalo, NY	61	40	13	3	3	2	5
Camden, NJ	17	5	6	4	1	1	1
Elizabeth, NJ	8	3	1	2	1	1	2
Erie, PA	43	34	6	3	—	—	5
Jersey City, NJ	U	U	U	U	U	U	U
New York City, NY	1,044	711	237	67	12	13	35
Newark, NJ	41	18	11	5	3	4	—
Paterson, NJ	12	6	3	2	—	1	1
Philadelphia, PA	260	158	60	25	5	12	14
Pittsburgh, PA§	23	13	6	3	—	1	1
Reading, PA	31	26	3	1	1	—	2
Rochester, NY	135	97	27	5	4	2	11
Schenectady, NY	12	11	1	—	—	—	—
Scranton, PA	24	20	4	—	—	—	1
Syracuse, NY	76	61	12	2	—	1	4
Trenton, NJ	18	12	6	—	—	—	1
Utica, NY	9	8	1	—	—	—	2
Yonkers, NY	U	U	U	U	U	U	U
E.N. Central	1,902	1,245	439	123	42	53	98
Akron, OH	57	39	11	3	3	1	3
Canton, OH	28	22	5	—	—	1	2
Chicago, IL	272	147	83	28	7	7	10
Cincinnati, OH	76	45	23	3	1	4	13
Cleveland, OH	205	150	41	6	5	3	3
Columbus, OH	196	129	42	17	4	4	13
Dayton, OH	115	82	19	6	2	6	7
Detroit, MI	179	94	56	21	4	4	9
Evansville, IN	44	34	7	2	—	1	—
Fort Wayne, IN	60	39	13	4	2	2	5
Gary, IN	11	8	1	1	1	—	—
Grand Rapids, MI	57	37	15	1	2	2	3
Indianapolis, IN	183	124	38	9	5	7	11
Lansing, MI	67	51	13	1	2	—	4
Milwaukee, WI	110	67	32	5	1	5	3
Peoria, IL	36	25	5	4	—	2	3
Rockford, IL	35	26	5	3	1	—	2
South Bend, IN	31	24	6	1	—	—	—
Toledo, OH	80	58	13	4	1	4	5
Youngstown, OH	60	44	11	4	1	—	2
W.N. Central	572	356	138	46	15	16	34
Des Moines, IA	—	—	—	—	—	—	—
Duluth, MN	24	20	3	1	—	—	1
Kansas City, KS	24	16	4	1	3	—	2
Kansas City, MO	91	58	24	6	1	2	5
Lincoln, NE	30	24	6	—	—	—	3
Minneapolis, MN	58	32	21	3	—	2	5
Omaha, NE	86	60	16	7	2	1	5
St. Louis, MO	144	68	40	21	7	7	6
St. Paul, MN	51	35	12	2	—	2	4
Wichita, KS	64	43	12	5	2	2	3
S. Atlantic	1,162	695	301	104	33	26	60
Atlanta, GA	170	87	53	22	6	2	6
Baltimore, MD	178	102	45	21	7	3	10
Charlotte, NC	109	67	25	7	5	5	11
Jacksonville, FL	164	91	45	16	6	4	8
Miami, FL	70	45	14	7	2	2	3
Norfolk, VA	33	23	7	2	—	1	—
Richmond, VA	56	31	22	2	—	1	4
Savannah, GA	49	36	11	2	—	—	1
St. Petersburg, FL	63	43	15	2	—	3	6
Tampa, FL	153	101	35	12	3	2	10
Washington, D.C.	100	58	25	11	4	2	1
Wilmington, DE	17	11	4	—	—	1	—
E.S. Central	875	556	218	58	23	20	63
Birmingham, AL	162	108	38	9	5	2	16
Chattanooga, TN	79	58	13	5	1	2	7
Knoxville, TN	114	75	29	5	3	2	2
Lexington, KY	73	48	15	5	2	3	2
Memphis, TN	156	78	52	18	4	4	14
Mobile, AL	95	65	18	4	3	5	5
Montgomery, AL	50	36	11	2	1	—	6
Nashville, TN	146	88	42	10	4	2	11
W.S. Central	1,371	847	321	112	47	44	56
Austin, TX	95	61	27	3	1	3	4
Baton Rouge, LA	53	38	10	2	1	2	2
Corpus Christi, TX	U	U	U	U	U	U	U
Dallas, TX	208	105	59	24	11	9	8
El Paso, TX	82	64	9	5	4	—	4
Fort Worth, TX	121	89	22	6	1	3	1
Houston, TX	370	207	101	37	12	13	19
Little Rock, AR	69	35	19	8	3	4	—
New Orleans, LA¶	U	U	U	U	U	U	U
San Antonio, TX	200	132	43	14	6	5	8
Shreveport, LA	60	44	11	2	2	1	5
Tulsa, OK	113	72	20	11	6	4	5
Mountain	841	507	209	68	29	27	31
Albuquerque, NM	100	68	20	7	4	1	1
Boise, ID	33	19	11	3	—	—	2
Colorado Springs, CO	55	36	13	4	2	—	2
Denver, CO	75	36	25	7	2	5	—
Las Vegas, NV	224	148	46	18	6	6	14
Ogden, UT	U	U	U	U	U	U	U
Phoenix, AZ	137	60	45	16	9	6	3
Pueblo, CO	31	22	7	1	—	1	1
Salt Like City, UT	62	39	15	2	2	4	2
Tucson, AZ	124	79	27	10	4	4	6
Pacific	1,542	1,044	323	106	44	25	85
Berkeley, CA	18	12	4	1	—	1	1
Fresno, CA	87	56	18	10	3	—	5
Glendale, CA	9	9	—	—	—	—	—
Honolulu, HI	49	32	12	4	1	—	—
Long Beach, CA	35	27	6	2	—	—	2
Los Angeles, CA	257	158	51	26	14	8	20
Pasadena, CA	15	9	2	3	1	—	2
Portland, OR	114	82	27	2	2	1	3
Sacramento, CA	192	130	39	13	8	2	9
San Diego, CA	158	104	38	11	3	2	15
San Francisco, CA	141	91	33	10	4	3	13
San Jose, CA	182	137	33	6	1	5	8
Santa Cruz, CA	23	15	6	2	—	—	—
Seattle, WA	108	70	22	9	5	2	5
Spokane, WA	55	42	10	1	1	1	2
Tacoma, WA	99	70	22	6	1	—	—
Total	10,565**	6,804	2,450	768	270	264	539

U: Unavailable. —:No reported cases.

* Mortality data in this table are voluntarily reported from 122 cities in the United States, most of which have populations of ≥100,000. A death is reported by the place of its occurrence and by the week that the death certificate was filed. Fetal deaths are not included.

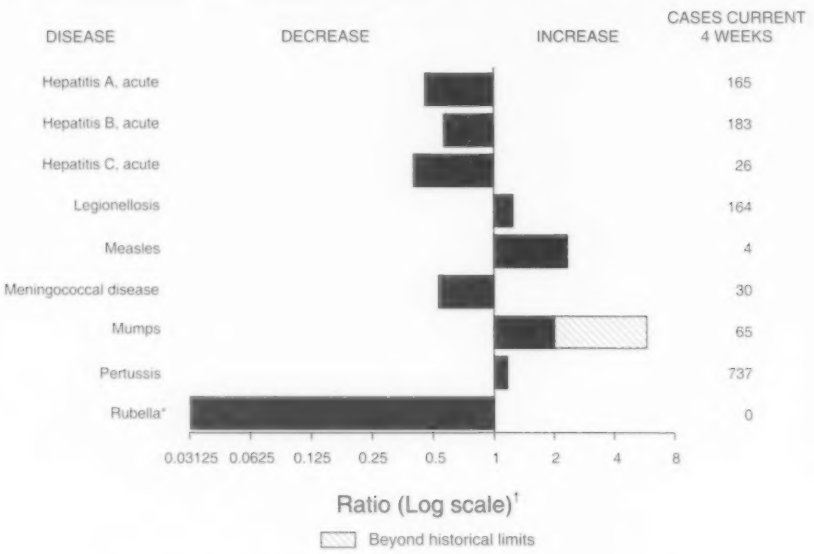
† Pneumonia and influenza.

§ Because of changes in reporting methods in this Pennsylvania city, these numbers are partial counts for the current week. Complete counts will be available in 4 to 6 weeks.

¶ Because of Hurricane Katrina, weekly reporting of deaths has been temporarily disrupted.

** Total includes unknown ages.

FIGURE I. Selected notifiable disease reports, United States, comparison of provisional 4-week totals September 2, 2006, with historical data



* No rubella cases were reported for the current 4-week period yielding a ratio for week 35 of zero (0).
† Ratio of current 4-week total to mean of 15 4-week totals (from previous, comparable, and subsequent 4-week periods for the past 5 years). The point where the hatched area begins is based on the mean and two standard deviations of these 4-week totals.

Notifiable Disease Morbidity and 122 Cities Mortality Data Team

Patsy A. Hall

Deborah A. Adams
Willie J. Anderson
Lenee Blanton
Rosaline Dhara
Vernitta Love
Pearl C. Sharp

The *Morbidity and Mortality Weekly Report (MMWR)* Series is prepared by the Centers for Disease Control and Prevention (CDC) and is available free of charge in electronic format. To receive an electronic copy each week, send an e-mail message to *listserv@listserv.cdc.gov*. The body content should read *SUBscribe mmwr-toc*. Electronic copy also is available from CDC's Internet server at *http://www.cdc.gov/mmwr* or from CDC's file transfer protocol server at *ftp://ftp.cdc.gov/pub/publications/mmwr*. Paper copy subscriptions are available through the Superintendent of Documents, U.S. Government Printing Office, Washington, DC 20402; telephone 202-512-1800.

Data in the weekly *MMWR* are provisional, based on weekly reports to CDC by state health departments. The reporting week concludes at close of business on Friday; compiled data on a national basis are officially released to the public on the following Friday. Data are compiled in the National Center for Public Health Informatics, Division of Integrated Surveillance Systems and Services. Address all inquiries about the *MMWR* Series, including material to be considered for publication, to Editor, *MMWR* Series, Mailstop E-90, CDC, 1600 Clifton Rd., N.E., Atlanta, GA 30333 or to *www.mmwrq@cdc.gov*.

All material in the *MMWR* Series is in the public domain and may be used and reprinted without permission; citation as to source, however, is appreciated.

Use of trade names and commercial sources is for identification only and does not imply endorsement by the U.S. Department of Health and Human Services.

References to non-CDC sites on the Internet are provided as a service to *MMWR* readers and do not constitute or imply endorsement of these organizations or their programs by CDC or the U.S. Department of Health and Human Services. CDC is not responsible for the content of these sites. URL addresses listed in *MMWR* were current as of the date of publication.

☆U.S. Government Printing Office: 2006-523-056/40070 Region IV ISSN: 0149-2195

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR DISEASE CONTROL AND PREVENTION (CDC)
ATLANTA, GA 30333

OFFICIAL BUSINESS
PENALTY FOR PRIVATE USE $300
RETURN SERVICE REQUESTED

93036 0001
PROQUEST INFORMATION & LEARNING
PERIODICALS ACQUISITION
PO BOX 1346
ANN ARBOR, MI 48106-1346

FIRST-CLASS MAIL
POSTAGE & FEES PAID
PHS/CDC
Permit No. G-284